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Editorial

The Editor notes with mixed emotions the increased bulk of the present issue of *Psychosomatics*. There is pride in growth, to be sure, but bulk alone is not enough. It is more important that the Academy and Journal continue to meet the needs of its members and readers—a most unusual group representing all areas of medical interest. Since anxiety is usually successfully repressed, and will soon become relatively inaccessible while it continues its subterranean existence, perhaps it is best that its roots are noted and labeled before they are covered and sealed from scrutiny.

The Academy of Psychosomatic Medicine and its official journal, *Psychosomatics*, in attempting to bridge the gap between medicine and psychiatry, are subject to the anxiety that is found in all gap-bridgers. The ground on either side may at times seem frozen and unyielding;

the divide itself often deep and impenetrable. Yet, strangely enough, there are many areas where access is provided—where the holds are secure and the gap is traversed with relative ease and comfort. The body-mind dilemma has been the “concern” of medical men throughout the ages because of an “either-or” philosophy rather than an acceptance of the need for co-existence. Life is supposedly simpler and the holds more secure when one decides to stick closely to the firmer interior rather than the edges. Nevertheless, hardy and seasoned travelers usually enjoy the trip across.

A round trip is being planned for Sunday, June 25th in New York City. A brief glimpse at the program and its participants on page 132 will convince the most skeptical that the ground will not be frozen in June.

W.D.

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*Hobbs, L. E.: The Use of Phenelzine, An Antidepressant, in General Practice. A Preliminary Report of 200 Cases, VIRGINIA M. MONTH. 36:692, (December) 1959.

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1. Rosen, H.: *Am. J. Psychiat.*, 107:917, June 1957.
2. Gesell, A., and Ilg, F. L.: *The Child from Five to Ten*. New York: Harper & Bros., 1946.

Abbreviations should conform to the style used in the Quarterly Cumulative Index Medicus.

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PSYCHOSOMATICS

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MARCH - APRIL 1961

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PSYCHOSOMATICS

Official Journal of The Academy of Psychosomatic Medicine

Psychotherapy for the Non-Psychiatrist

KLAUS W. BERBLINGER, M.D.

WAGNER:

*Ye pardon me, I've just heard you declaiming,
It surely was a Grecian tragedy or play.
At profit in this art I'm also aiming,
For much it can impress today.
I've often heard the boast: "a preacher
might take an actor for his teacher."*

FAUST:

*Yes, if the preacher is an actor there's no
doubt,
As it indeed may sometimes come about.*

GOETHE.

Psychiatrists, who have become or who consider themselves experts in the field of human relations, do not or should not want to teach tricks or even methods alone. One would prefer that the non-psychiatric specialist attend his patient to the full measure of his own capacity, be the patient's predominant needs expressed in terms of emotional or bodily distress.

Thus, in view of the ever increasing interest in the psychological factors inherent in medical illness and of the mushrooming educational and informational enterprises on the postgraduate level, a reappraisal of the usefulness of our enthusiasm seems indicated indeed. It may be a sacrilege to frankly admit this in your company; it may even turn out to be an agonizing reappraisal in fact. The fault, likely, rests not so much with the method

of instruction which gradually seems to have shifted from a pontifical lecture to involvement with patients, as with inadequate attention to what the non-psychiatrist wants and needs whenever he has to deal with the psychological components and implications of his patients' illnesses.*

One should therefore attempt to provide a conceptual frame of reference of what constitutes psychological factors and of what is meant by medical psychotherapy. Moreover, such a conceptualization should be applicable to the care of patients in all specialties of medicine.

In straight, or orthodox psychoanalysis and psychotherapy—though they may furnish the model of approach—certain basic assumptions and agreements exist between the patient and his doctor. Even the marginally sophisticated participant of 20th century America knows a number of conditions before consulting a psychiatrist. He acknowledges that he has to get sick "on time," that he has to venture to the psychiatrist's office, and that both he and the doctor have to profess a unifying belief in the existence of unconscious motives for current behavior. The patient also—thanks to Robert Lindner's book ti-

From the Department of Psychiatry, University of California School of Medicine, and the Langley Porter Neuropsychiatric Institute, San Francisco, California.

Read before the Panel on Psychiatric Education for the Non-Psychiatrist at the Seventh Annual Meeting of the Academy of Psychosomatic Medicine, Philadelphia, Pennsylvania, October 15, 1960.

*The degree to which educational projects for non-psychiatrists in spite of dissimilar planning tend to become more and more process oriented may be illustrated by two examples. One concerns the Western Interstate Commission for Higher Education project "Postgraduate Education in Psychiatry for Physicians in Isolated Areas." This project, under the auspices of the National Institute of Mental Health, is entering its second year, and was intended to allay the objective shortage of qualified psychiatrists in the western states. As the courses, which are being held in small communities and conducted by qualified psychiatrists in the vicinity of small urban medical centers have progressed, participants, teachers and evaluators report a marked shift from concern with the diagnosis of psychiatric disabilities to the therapeutic management of psychologic concomitants in medical illness. An identical trend is seen in the review of psychiatric postgraduate education at Langley Porter Neuropsychiatric Institute over a course of 15 years.

tle—is appraised of the fact that a psychiatric hour lasts fifty minutes, that talking out one's problems will help and that it will cost a specified amount of money over a protracted period of time. Since all of this is considered implicit in the more formal modes of psychotherapy, the initiation of a doctor-patient relationship does not constitute too great a problem in this context.

Psychotherapy Initiated by the Non-Psychiatrist

For the non-psychiatrist the matter is rather less comforting. If he is asked to apply psychiatric principles and techniques to patients with acute or chronic medical disorders, he may experience the disconcerting feeling that he has to sneak his psychotherapy in through the backdoor. In turn, he might consider this to be a subterfugal and dishonest approach and such self-scrutiny may herald resistance on the physician's part. Physicians are justified in priding themselves on talking straight from the shoulder to their patients. Yet, the presenting medical symptoms like headaches, backaches, pelvic complaints or gastric distress may mask a conflict which creates sufficient anxiety for the patient so that he cannot face it squarely. Setting the stage by explaining negative physical findings, or—to express it in a more positive fashion—reaffirming the patient's intactness of body, may have a reassuring effect for the moment. It may even last if the patient firmly believes in his doctor; in other words, as far and as long as a positive doctor-patient relationship is already in existence. However, if such is not the case, negative findings merely deprive the patient of a costly defense and his anxiety will mount to the point where he goes shopping for other means of emotional support.

Objectives and Means of Medical Psychotherapy

Our efforts at psychosomatic orientation and instruction in medical psycho-

therapy should therefore clearly state the objective and the ways in which medical psychotherapy can be realized. One might return to a previous definition that "medical psychotherapy is that part of medical practice in which relationship constitutes the principal or at least, an essential therapeutic agent."¹

Least disagreement seems to exist in the realm of objectives. As in all other therapies, restoration of homeostasis and achievement of social functioning on a pre-morbid level, remain the accepted or at least tacitly acknowledged goals. The conduct of effective medical psychotherapy hinges upon four prerequisites:

- (1) Expectation
- (2) Communication (verbal and non-verbal)
- (3) Ventilation, and
- (4) Correlation

As far as *expectation* is concerned, this remains probably the most elusive factor. But it goes without saying, that previous experiences of the patient with the same or other physicians must slant the initial impact of a doctor-patient relationship. It is well known that the miracle cures of Lourdes in France are inversely proportionate to the distance which the help-seeking applicant has to travel in order to reach the shrine. Cures there—which, incidentally, are no more frequent than spontaneous remissions—are also more liable to occur if the pilgrim arrives on the same train with other professants.³ The analogy to current admission procedures in our hospitals and offices should be self-evident.

When it comes to *communication*, the problem increases in complexity. However, it also reverts to greater conscious and intentional control by the physician. Communication has been defined as "all of those means and devices by which people affect or take influence upon each other."⁴ In the medical setting, communication must be patient-centered. The physician

who is familiar with disease entities, their symptoms, and consequences is sometimes too prone to look for what he has been accustomed to. This he may validate in terms of his own medical life experience. Thus, he may omit or overlook obvious, though seemingly irrelevant clues or leads in the patient's account. The equally obvious result may become a deterioration of the patient's feelings for his physician as the former will feel ill-comprehended or misunderstood. To quote examples, we may have a patient who arrives at the office with vague gastro-intestinal complaints. "I have a pain in my stomach, Doctor . . ." may be countered with inquiries into location, post- or pre-prandial distress. Other well known and medically anticipated symptoms may lead to questions like, "Does this pain occur before or after meals?" and may be answered by, "I never eat breakfast." The physician, still unmindful of seemingly irrelevant clues, may retaliate that he is really not interested in the patient's breakfast habits, but rather in certain sensations following the intake of food. The patient remains unyielding and insists upon his early morning abstinence. Now, what about another approach or system of inquiry? If the doctor would ask, "Why don't you eat any breakfast?" the patient might volunteer that he works on the night shift as an undertaker's assistant, that whenever he comes home, his wife is about to leave for some secretarial occupation, that his children are in school, nobody cooks breakfast for him and that he feels uncared for.² Well, it is obvious that through proper attention to clues, here an entirely different picture emerges which resembles depression more than gastritis. Another physician may see a patient for precordial pains, but fail to take cognizance of a bandaged finger. This doctor should not be surprised if the patient demands a return of his money. It is the *acknowledgment*, not necessarily the *satisfaction* of a patient's implicit

clues or presenting needs which firmly cements an early doctor-patient relationship and thus—in spite of what was cited as unspoken or non-verbally defined agreement in formal psychotherapy—opens the way for medical psychotherapy more than any theoretical or factual explanation about mind-body interdependence. The patient feels understood beyond the capacity of his own intellectual awareness.

Ventilation, the third postulate, conceives of the physician as a facilitator of communication. A well known actress stated why the late Max Reinhardt remained her favorite director. "He would show me," she said, "not how I wanted to play a part, but how I *could* play it not alone, but with *his* help and understanding of my own means." Such an analogy may lead us into the relief affording aspects of a patient's ventilation or "letting off steam."

A close bond exists between ventilation and *correlation* of symptomatology and precipitating social and emotional stress. The physician who recognizes verbal and non-verbal clues which are indicative of an area charged with emotional or social importance, can facilitate the patient's verbal expression, afford him relief through ventilation, pre-conscious awareness, with or more often without, intellectual insight.

Whatever we are unable to express in language, be it for reasons of anxiety or absence of information, we actually do not know. Thus we become incapable or reluctant to admit contradictory feelings to awareness and are rendered impotent to solve pressing conflicts. The result will be that we cannot master the tasks which beset us and we may fall ill to any length and to any degree. On the other hand, being able to express difficulties in words and thoughts is, in our culture at least, the accepted, preferred and superior mode of saving one's intestines from ulceration or hypermotility.

The Physician as a Psychotherapist

While the initiation of medical psychotherapy may conceive of the physician merely as a facilitator of communication, progressing treatment places him into a role where he represents symbolically the person who is under discussion. A father with ulcer pains may talk about the impending wedding of his favorite daughter; he may bewail the dowry, may be suspicious of the prospective son-in-law's morals. He may admit his feelings of impending loss and his reluctance of sharing the remainder of his days with an ever-nagging wife. The physician who can focus on such an area becomes a dependency substitute. Although he may not knowingly or admittedly be rewarded for his psychotherapeutic skill, his probanthine medication may find itself of increased psychopharmacological helpfulness for his patient. This may sound disappointing to the psychologically oriented physician's ego, but we may repeat with Freud "that everything that helps a patient is good treatment."

Professional Control in the Doctor-Patient Relationship

Inferred in such an interpretation of doctor-patient relationship is the unalterable fact that by virtue of his training and experience the doctor must remain in control and therefore must be authoritative, though by no means authoritarian. One should not attempt to make decisions for the patient merely based on one's guess, hunch, or one's own life experience. On the other hand, decisions based on psychological insight or medical judgment remain unavoidable. Therefore, it seems like an impossible distortion of psychotherapeutic permissiveness when a tuberculosis specialist asks his patient whether he does or does not prefer chest surgery, or if a neurosurgeon leaves the ultimate decision—not permission—for a disk operation to his patient. Included in a truly psychotherapeutic medical approach is the unpleasant fact that as doctors we have to

be able to tolerate a certain amount of anxiety about the unpredictable or even the principle of uncertainty itself. Whenever we relegate this to the patient, we have not completely fulfilled our mission.

The Problem of Professional Identity

Another problem concerns the fear of loss of one's professional identity whenever a non-psychiatrist undertakes psychotherapy. It is, for instance, said that an internist, once he has become aware of psychological factors, might underplay his diagnostic skills, sit back in a chair and "behave like a psychiatrist." This can be obviated in various ways. First of all, emphasis on precipitating or presenting complaints will not only preserve a patient-centered approach, but give the physician an opportunity to apply his accustomed medical measures. Interviewing techniques should not become isolated or detached from the usual approach to patients. Once the doctor has acquired mastery of attention to verbal clues and behavioral manifestations, he may interview or interact while he takes a medical history or executes routine diagnostic procedures, like measuring the blood pressure or even while he collects a blood sample.

How to Appraise One's

Psychotherapeutic Competence

The specialist in any of the psychotherapies relies on lengthy training in psychodynamics, conduct of doctor-patient relationship through supervision, and this is often supported by insight into one's own problems through personal psychotherapy. Whether all three of these modes of instruction are essential to the conduct of medical psychotherapy remains open to question. However, as the non-psychiatrist enters purposefully the field of psychological influence on his patient, he should at any given time be prepared to ask himself three questions:

- (1) What did the patient say?
- (2) Why did he say it?
- (3) Why did he tell me this at this moment?

Simple as these questions may sound, they cover considerable ground. *What* the patient says constitutes the content of his communication; the *why* relates to his motivations, while the *why* and *when* refer to the status of doctor-patient relationship in past, present and future interaction. Whenever any of these questions remain unanswerable for any length of time, the physician must scrutinize his position as a therapist in terms of his own knowledge and approach. In other words, he must try to decipher the meaning of communication between himself and his patient as well as his ability to understand and to make the correct inferences. Thus, self-scrutiny and re-evaluation of the patient's overt or implied behavior is similar to any other diagnostic and therapeutic approach in medicine and should allay the fear that once the physician has

become a psychotherapist, the broom may rule the sorcerer's apprentice.

SUMMARY

The integration of medical psychotherapy with the daily practice of medicine conceives of the psychological variable as communication therapy. Its initiation, conceptualization, objectives and limitations have been described in terms of the recognition of psychological clues and doctor-patient interaction.

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It takes a lot of variables to describe a man or, for that matter, a virus; and you cannot often usefully study these variables two at a time. Animate nature also exhibits very confusing instabilities, as students of history, of the stock market, or genetics are well aware.

Warren Weaver—Presidential Address at the American Association for the Advancement of Science.

(Quoted by Robert Waclder, "Basic Theory of Psychoanalysis," International Universities Press, New York, 1960, p. 7.)

Some Psychiatric Syndromes in Internal Medicine

VICTOR SZYRYSKI, M.D., PH.D.

INTRODUCTORY NOTE

The chart that follows was prepared to summarize a presentation before a meeting of a district medical society in North Dakota. It contains primarily the less frequently seen conditions which are more likely to baffle the internist and the psychiatrist alike. It does not cover such well known conditions as cerebral arteriosclerosis, alcoholism, and other toxic psychoses, brain tumors, etc. For the same reason, the clinical pictures outlined are not the most typical ones, but in some cases the rare manifestations of the enumerated conditions were given preference over the classical textbook descriptions. The great majority of them, however, are based on well documented cases observed by the author.

It should always be remembered that

in organic brain conditions two main factors are responsible for the final clinical picture: The organic cerebral pathology and the pre-morbid personality which responds and adjusts to the brain lesion. Organic brain syndromes are usually classified into a) the acute form of delirium with disorientation, excitement, hallucinations of the organic type, and possibly fever, exhaustion, and physical collapse; b) the chronic syndrome of dementia with impairment of memory, orientation, and judgment. Although one or the other of the above patterns is found in the majority of brain disorders associated with medical conditions, in a number of them psychiatric manifestations would imitate numerous neurotic or psychotic conditions not readily identified with the typical "organic pattern."

<i>Psychiatric Manifestations</i>	<i>Medical Condition</i>	<i>Some Other Clinical Findings</i>
"Termagantic personality," aggressive, hostile, resentful, demanding, overcritical; "paranoid" or "neurotic." Recurrent trend of the above symptoms. (Kark)	Porphyria	Gastric colic, peripheral neuropathy, port-wine urine (or turns red when exposed to sunlight), made worse by barbiturates; porphobilinogen and uroporphyrin in urine.
Fatigue, general weakness, anorexia, depression, general apathy.	Hyperparathyroidism	Diminished or absent reflexes, history of nephrolithiasis, polydipsia and polyuria; positive Sulkowitch test for Ca in the urine. X-ray of the teeth: resorption of the lamina dura, elevated serum Ca and low serum phosphorus (with checked protein level).
Fatigue, irritability, depression, paranoid delusions, occasional confusional states, "myxedematous madness." (Asher)	Myxedema	Sensitivity to cold, change of voice, puffiness of face, cold hands, slow pulse and low pulse pressure, Woltman's sign, anemia, low BMR and PBI, abnormal EEG and ECG. Elevated blood cholesterol and CSF protein.

Presented before the District Medical Society Meeting in Jamestown, North Dakota, Jan. 1961.

Psychiatric Manifestations

Anxiety, emotionality, hyperactivity, irritability, depression, agitation, paranoid delusional states, delirium with restlessness, hallucinations, excitement and insomnia: "thyroid storm."

Hyperirritability, quarrelsomeness, restlessness, negativism, occasionally stubbornness, anxiety, confusion, excitement and delirium; stupor, coma.

Fatigue, apathy, anxiety, irritability, persecutory ideas, lethargy, loss of appetite.

Apprehension, suspiciousness, agitation, depression, delusional preoccupations; occasional delirium with confusion and hallucinations. Intellectual deterioration with poor memory, concentration and judgment.

Acute anxiety with tremor, palpitation, dyspnea and restlessness. Confusion may follow.

Irritability and excessive emotionality, impatience, fatigability, difficulty in swallowing.

Recurrent episodes with changes in personality, untidiness, negligent and uninhibited behavior. Disorientation, irritability, occasional violent outbursts, unresponsiveness, lethargy, rigidity and coma. Recovery may occur after a few days.

Anxiety and fatigability. Delirium with excitement, elation and disorientation. Depressive or schizophrenic disorders.

Fluctuating confusion and disorientation. Impaired memory. Episodes of stupor. Usually no hallucinations or delusions.

Korsakoff's syndrome with impairment of memory and confabulations. Disorientation, especially to time.

Medical Condition

Hyperthyroidism

Hypoglycemia from:
—pancreatic adenoma;
—overdosage of insulin;
—malingering (from self administration of insulin)

Hypopituitarism (Sheehan's and Simmond's disease)

Pernicious anemia

Insidious internal bleeding (e.g. oversensitivity to aspirin)

Myasthenia Gravis

Hepatic encephalopathy ("portal systemic encephalopathy" of Sherlock)

Disseminated lupus erythematosus

Subdural hematoma

Subarachnoid hemorrhage (Goldflam)

Some Other Clinical Findings

Loss of weight, increased appetite, fast pulse, high pulse pressure, thyroid bruit, warm hands, exophthalmos and ocular signs, diarrhea, high BMR and FBI. ("Masked hyperthyroidism" may occur.)

Hemiplegia, other focal neurological signs, diplopia, ataxia, tremor, convulsions. EEG changes. Hunger, weakness, perspiration, low blood sugar level.

Loss of axillary hair and amenorrhea in females, combined hypothyroidism and adrenocortical insufficiency. (To differentiate from anorexia nervosa.)

Weakness, pallor, red atrophic tongue, shortness of breath and palpitation. Ataxia and paraparesis with spastic signs. Macrocytic, hyperchromic anemia with achlorhydria. (May be masked by "vitamin pills.")

Pallor, rapid pulse rate, may be history of tarry stools with previous intake of aspirin. Severe normocytic anemia.

"Thick speech" after talking for some time; quick tiring of other muscle groups; diplopia, drooping eyelids, typical response to prostigmin with quick improvement of strength.

Ataxia, uncoordination and awkwardness. Ankle clonus. "Flapping" tremor. Abnormal EEG with bilateral frontal slow waves. Abnormal liver function tests. Elevated ammonia in the blood. Recurrences over a period of a few years.

Recurrent fever, hematuria, "butterfly" rash on the face, pleuritis, pericarditis, convulsions. Increased ESR and positive LE cells. Abnormal EEG. WR may be positive.

Severe headache, may be history of head injury, abnormal EEG, papilledema, focal neurological signs may be present. Shift on pneumoencephalogram. Positive burr-hole findings.

Sudden onset of headache (as if hit at the back of the head), positive meningeal signs. Subhyaloid hemorrhages. May be papilledema. Blood in the CSF. Massive albuminuria and occasional glycosuria. During recovery period: severe lumbosacral pains with sciatica-like radiation.

<i>Psychiatric Manifestations</i>	<i>Medical Condition</i>	<i>Some Other Clinical Findings</i>
Weakness, anorexia and depression in prodromal stage. Confusion and disorientation, impairment of memory, delirium. Drowsiness and coma.	Temporal arteritis	Severe temporal pain with extreme tenderness; bouts of high fever. Thick and nodular artery. Diplopia, ptosis, blindness from obstruction of retinal artery. ESR markedly elevated.
Progressive dementia with impairment of orientation, memory and concentration. Mental confusion and irritability.	Occlusion of the internal carotid artery (Miller-Fisher)	History of transient pareses or aphasia. Carotid or ocular bruit. Unilateral absence of carotid pulse.
Acute delirium with restlessness and violent behavior of sudden onset.	"Congestive attacks" of general paresis	Positive WR in CSF. "First zone" positive gold colloidal curve.
Impairment of memory, poor concentration, recurrent disorientation, persecutory delusions.	General paresis (Lissauer's Type)	Epileptic seizures. Focal neurological (e.g. facial paralysis) and EEG abnormalities. Positive luteic findings in CSF. Recovery with penicillin therapy.
Emotional instability, irritability, apprehension, depression, fatigue, negativism, lack of drive, procrastination, lack of appetite, weight loss.	Addison's disease	Weakness, nausea, diarrhea, abdominal pain, hypoglycemic episodes, dark-brown pigmentation of the skin, especially pressure points and blackish in the mucous membranes; low blood pressure; normochromic anemia. Low urinary 17-ketosteroids and 17-hydroxycorticoids. Abnormal response to ACTH (Thorn test). Low BMR, x-ray: calcification of the suprarenals may occur. Danger of acute crisis.
Change of personality, increased irritability, aggressiveness and impatience, hostility, persecutory ideas, rapid changes of mood. Occasionally full psychotic reaction with paranoid trends.	Cushing's Syndrome	Obesity with "moon face" and "Buffalo hump" distribution of fat. Protein depletion with muscle weakness, fragility of bones and blood vessels, abdominal striae. Hirsutism. Hypertension, florid face, amenorrhea, osteoporosis. Increase of urinary steroids.
Loss of sleep with restlessness at night, nocturnal attacks of anxiety. Emotional lability and irritability. Occasional confusion with disorientation; inappropriate behavior, restlessness, apprehension and visual or auditory hallucinations. Full blown delirium may occur.	Congestive heart failure. Cerebral anoxia. Coronary occlusion	History of heart disease. Nocturnal dyspnea, pulmonary congestion and edema, ascites, enlarged liver, engorged neck veins, cyanosis. Precordial pain. Abnormal ECG.
Poor sleep, restlessness, lack of energy, poor concentration, failing at school or at work, loss of appetite, irritability.	Chronic uremia	Thirst, nausea, vomiting, diarrhea, headache, muscular twitchings, nocturnal dyspnea. Increased nitrogen products in the blood.
Acute delirium with confusion, restlessness, excitement and hallucinations—mainly in older, undernourished people.	Acute nicotinic acid deficiency encephalopathy	Sucking and grasping reflexes, jerky movements of legs and arms, cogwheel rigidity. Responds only to very high doses of niacin.
Progressive dementia; impaired memory, concentration, initiative and attention. Eventually confusion, disorientation and delirium with excitement and hallucinations.	Pellagra	History of malnutrition. Dermatitis, diarrhea. Responds to niacin.
Neurasthenic syndrome with fatigue, weakness, forgetfulness, poor concentration—eventually confusion and delirium.	Thiamine deficiency: Wernicke encephalopathy	Malnutrition; alcoholism, impaired absorption, gastrointestinal pathology. Paralysis of conjugate gaze. Nystagmus. Ocular incoordination.

Psychiatric Manifestations

Mental deficiency of early onset. Fair hair, blue eyes, muscular rigidity, occasionally walking only on the toes.

Confusion, hallucinations, restlessness, running away, violent resistance to control, stupor, disorientation concerning persons, time and place. Progressive clouding of consciousness and collapse in severe cases.

Nervousness, agitation, excitement and violence, confusion with hallucinations. Delirium followed by stupor and coma. May resemble delirium tremens.

Medical Condition

Phenylketonuria

Febrile delirium in pneumonia, typhoid fever, malaria, etc.

Magnesium deficiency

Some Other Clinical Findings

Phenylpyruvic acid in acidified urine gives green color with a few drops of ferric chloride. Metabolic defect blocks conversion of phenylalanine into tyrosine.

Symptoms and signs of coexisting illness. In postfebrile delirium temperature may be normal and most signs already absent.

Ataxia, muscular twitchings, choreiform and athetoid movements, tetany resembling hypocalcemia syndrome, convulsions, normal blood Ca and no effect of Ca I.V., slow improvement with magnesium sulfate I.M.

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If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away.

Thoreau.

I was grateful to be able to answer promptly, and I did. I said I didn't know.

Mark Twain.

School Phobia

ADAM J. KRAKOWSKI, M.D.*

Among conditions which confront the pediatrician and the general practitioner, but usually require psychiatric intervention, are various syndromes which produce either the refusal of the child to attend school, or pathological reactions in response to school attendance. Within this broad category school phobia occupies a special place. Early recognition of this neurotic illness is important, since its proper treatment depends greatly upon understanding its specific nature. Failure to understand its psychogenesis and dynamics leads to unnecessary and involved somatic investigations and an increase in the difficulties. In addition, unnecessary transfers may result from erroneously placing the blame on the present school; although, on occasion, the school may be at fault, in most cases school phobia does not arise from this source.

Phobia is defined as a morbid fear associated with morbid anxiety¹ in which the anxiety becomes attached to a specific object or situation. Such an object or situation does not represent to the patient the real source of danger per se and the patient, as a rule, is fully aware of the fact that there actually is no reason to be afraid of this particular dreaded object or situation. However, the mechanism serves the purpose of intellectual defense against the unconsciously perceived threat, thus permitting the patient to avoid, intellectually avert, circumvent or neutralize and control the anxiety.²

School phobia is but one of many phobias present in childhood, for children are very prone to the symbolic type of defensive mechanisms and particularly susceptible to separation fear.³ Freud divides phobias into the common and the specific types. The former are exaggerations of

fears existing in everyone under certain conditions such as illness, death, abandonment, darkness, wild animals and the severe stressful effects of the elements of nature. The specific types are related to objects or situations which do not appear dangerous to normal people. Here belong such phobias as claustrophobia, agoraphobia, etc.⁴

Since this presentation is necessarily brief I will omit discussion of the more involved dynamics of anxiety leading to phobias and merely mention that the leading schools of psychiatry consider such anxiety to be generated by the necessity of sex repression.

The nature of all childhood phobias, but particularly of school phobia, exemplifies one of the essential qualities: an unresolved dependence relationship of the child with its mother. The history of the parents, but particularly of the mother of a phobic child, frequently shows that she is similarly phobic and has an unusually strong dependence upon her child. The latter factor appears evident at all times, or is displayed overtly just before the child becomes phobic. An illustration is evident in cases of school phobia which occur in children whose families have lost another member through recent death.

The general psychodynamics of phobias involve a conflict between the instinctual drives and the demands of the ego. The impulses produced by the drives and inhibited by the restrictions give rise to a free-floating anxiety. To avoid this, a defense mechanism is set in motion in which displacement plays a paramount role. This mechanism substitutes a symbolic, seemingly less painful object for the more threatening internal danger of the free-floating anxiety. The tendency to neutralize anxiety is by no means foreign to other forms of neurosis, since it is easier

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to cope with a known than an unknown, indefinite danger. The choice of the new object or situation used in displacement appears to be a matter of accidental selection, yet there seems to be a link between the nature of the original and the new object or situation used in displacement. The nuances of the symbolisms are not always simple, and one object may not always fulfill the neutralizing role; the patient may require that several phobic mechanisms exist concurrently, although the conflicting cause may be simple. Similarly, the extension from one object to several appears to fulfill the increasing needs of the mounting anxiety. Both the complexity of the phobic displacements and the extensions will operate as long as the individual is not sufficiently protected from the danger.

School phobia is apparently more predominant in girls; it is manifested by panic states related to going to school. Until its onset, which may follow an organic illness in the patient, or some exogenous situation such as sickness in the family, school phobic children show undisturbed attendance and normal scholastic progress.⁵ Since unwillingness to attend school or severe emotional reactions related to school attendance are not necessarily confined to school phobia, we must observe the distinguishing factors of this phobia. School phobic children react with acute anxiety in a violent manner when forced to go to school. They occasionally, if not frequently, manifest somatic-like symptoms and display compulsive features. However, they do not always react with anxiety to other social situations. Once out of school, they develop a secondary fear that they will not be able to catch up with others. When asked about the reason and the nature of their fearful feeling they can produce no adequate explanation; as their absence from school becomes prolonged they rationalize that they are afraid to return to school for fear of scholastic failure. As

a rule, they do not at first express hostility toward their peers or fear of the teacher, but then, becoming suggestible to parental persuasion, they may become fearful of the teacher. They usually admit that they have liked the school and cannot find any reason why they suddenly started to fear it. In response to skillful interview, however, the majority of the patients express severe fear and concern about another member of the family or the possibility of a catastrophe in the family. This, on occasion, may have rational, factual basis but very frequently such fearful suspicion is absolutely unjustified. Many of these children show the presence of other common phobias. Somatic symptoms are occasionally present and these may be purely of phobic nature or may be iatrogenically produced. Involved diagnostic investigations pertaining to these somatic symptoms frequently produce very severe fixation.

The investigation of the family background of school phobic children, and of the relation of the patients to others, reveals factors already listed, but particularly the presence of an unresolved dependency situation with the mother. The latter might have recently sustained a loss or has been exposed to a threat which produced in her a need for an increased dependence on the child. Fulfillment of such dependence on the child may be profitable to the mother but it has a traumatic effect on the child making separation from the mother impossible.⁶

The following clinical case is a typical example:

Gail was referred to the clinic at the age of nine following several months' absence from school. She had always been a sickly child with a tendency to constipation, and has always been babied by her over-solicitous mother. Her developmental history was not remarkable nor did she have any severe illness during early childhood. Though enrolled in school at the age of four, she refused to stay. She was sent to the first grade at five. Her scholastic achievement was always good. At the age of eight she developed some abdominal complaints and was out

of school for five weeks. Upon recovery, she became fearful of returning, but was forced by her mother to return and subsequently she was promoted to the fourth grade. During the following winter she was absent for three weeks because of an upper respiratory infection. In spite of her fear of school she returned under force. About that time she developed severe constipation and abdominal pains; cathartics were prescribed by the family physician, and the child was hospitalized for fecal impaction. Because of this she was again absent from school, and when she recovered she refused to return. Encouragement and threats were futile, she became nauseous, complained of abdominal pain whenever school was mentioned. She became carsick and phobic of airplanes, and then reverted to thumb sucking. Although shy, she played frequently with her friends; she was not fearful of skating and was able to participate in girl scout activities. Gail's mother was concerned, but decided that it was impossible for Gail to attend school because of her somatic illness. The mother, a nervous individual who easily loses her temper, stated she had a satisfactory marital relationship but admitted she was jealous of her husband. The father was described as an able businessman; he was nervous, with many phobias (including fear of crowds). The latter phobia was so severe that he could not attend church. He fainted when confronted with a crowd. Gail's elder sister, age 15, was an outgoing, sociable, dependable, independent and aggressive girl who has shown excellent scholastic progress.

During the first contact, in the clinic, Gail was ill at ease, extremely tense and gave no verbal responses whatsoever. The psychometric testing credited her later on with an IQ of 96. Further contact revealed that the patient related all her fears of attending school to the presence of her alimentary complaints. Some free-floating anxiety was still present. Her difficulty when forced to go to school appears to have been a panic reaction with resulting inability to do any of the school work.

As the patient and her mother entered therapy in the clinic, Gail became more outgoing and apparently much less dependent upon her mother. After about three months, without any warning, they failed to return. The patient was heard from again close to four years later. This time Gail was absent from school for about three months and referred to the clinic by her mother, when the family physician's medical certificate was not acceptable to the authorities. The interview with the mother brought out a considerable dependence on the patient and showed that Gail's presence at home served the purpose of

keeping the mother there; otherwise she would have gone to work. When interviewed, she stated that in spite of her wish to work outside she appreciated the fact that she should take care of her daughter who needed her help. Apparently Gail returned to school following therapy, but during the current school year she quit after three weeks because of rather severe upper abdominal pains, nausea and vomiting, present when she was in school but never occurring at home. She projected all her feelings this time on the particular school she attended, and therefore the transfer to another school was contemplated by the mother. At the same time she was not fearful of going to dances or attending a school for ball-room dancing.

This clinical example describes a patient who on each occasion of the onset of school phobia was treated by her family physician for a rather prolonged period before the referral to the Child Guidance Clinic was effected. Initially the absences from school, for an apparent physical illness, appear to have been unnecessarily prolonged by the mother who was obviously over-indulging the patient. The role of the physician, or the iatrogenic component of his overpermissive or unconcerned attitude towards the prolonged absences from school should be emphasized. This particular family physician apparently did not realize that such prolonged absences from school may produce fear of failure in most young patients. The next iatrogenic influence seen in this case appears to be Gail's fixation at the level of the intestinal disturbance. This fixation increased somatization during the second and most recent attack. The element of the unresolved relationship between Gail and her mother is obvious; the type of the original phobic reaction, the presence of phobias in the father and the other phobias in the patient are quite evident.

The second clinical case summarized below appears to be slightly different but is an extremely typical example of a school phobia:

Janice, a ten-year-old girl, was referred by her mother because of refusal to attend school; she also became severely upset in school when forced

to attend. Janice was very happy in kindergarten and the first grade. While she was in the second grade the family became very upset by the discovery of a congenital cardiac condition in a four-year-old sibling of the patient. Cardiac surgery was finally performed, but the child died post-operatively. During that time the patient was somewhat neglected, since little attention was paid to her by her mother. At the onset of her illness the parents seemed to be very tense and the mother placed much responsibility for the other siblings on the patient who was very dependable. After Janice developed symptoms, the mother appeared rejecting. She was quick-tempered and quarrelled frequently with the patient's father who avoided difficulties by spending little time at home.

Janice was described as a very sensitive child, a perfectionist who was easily discouraged in spite of the fact that she did very well scholastically. If criticized for a mistake she appeared panicky. She showed many compulsive features with regard to cleanliness; after the onset of illness she became the defender of her sibling, was overreligious and ritualistic.

The examination revealed a very tense and anxious child. The symptomatology consisted of severe states of panic while in school, related to fear that all other members of the family might die while the patient was away in school. The onset was pinpointed by her to the time of the death of her brother. She realized that no other member of the family, nor herself, had cardiac illness, yet she still could not control her fears that other members of the family might suddenly die an accidental death. She expressed feelings of guilt for not being a perfect person and showed evidence of other phobias. The psychometric testing credited her with an average level of intelligence.

The circumstances leading to formation of the phobia in this patient are somewhat different from the case previously described. The onset of anxiety and the phobia appears to be related to the death of the patient's brother with the mechanism of displacement of the anxiety to the school. Compulsive obsessive phenomena are quite strong in this patient; perhaps due to their existence the patient has been able to attend school most of the time.

TREATMENT

The treatment of phobias, as of any form of neurosis, is best accomplished by psychotherapy. Many phobics tolerate their affliction for many years, and al-

though limited in their freedom and comfort, they are able to adjust through the mechanism of conscious avoidance. In more severe phobias, the phobic extensions make it impossible for the patient to lead anything but an extremely limited life. In school phobias the condition requires prompt psychiatric intervention.

Despite his orthodox methods of treatment of neurosis, Freud himself advocated a more direct approach to the treatment of phobias.⁷ Desensitization may be imperative. In school phobias this factor is extremely important, since the uncovering process with the use of a dynamically oriented psychotherapy may be time-consuming and the patient may offer severe resistance. The parents who condone the behavior and fixate the displacement may finally become rejecting because of the child's adamant refusal to return to school. Blaming or accusing the school for alleged improper handling of the child (a fact which cannot be completely disregarded as causative or aggravating in some cases) may be a source of unnecessary delay in the institution of treatment.

It is advisable to draw the attention of the non-psychiatrist to a few relevant "do not's" in handling school phobic patients.

The period of absence from school, following an illness, should be as short as possible; if prolonged convalescence is advised, home teaching is imperative to enable the child to continue scholastic progress comparable to that of his peers, thus facilitating his return to school without fear of failure. Secondly, the initial diagnosis must not utilize the principle of diagnostic exclusion. One must remember that the diagnosis of neurosis cannot be made solely because one was able to rule out an organic illness, nor that one is entitled to exclude the presence of organic disease because of the existing neurosis. Furthermore, involved investigations, including hospitalization, are to be avoided if possible; prolonged investigations when the patient has somatic complaints so typ-

ical of phobias, lead to iatrogenic illness. The excuse from school granted by the family physician is in no way, in itself, the solution for a phobic child. Equally futile is an endeavor to force a child to believe he has no reason to fear his symptoms. Such technique is frequently responsible for the appearance of additional phobias, their extensions, somatizations and obsessive symptomatology.

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And certainly the respect for greatness, especially intellectual greatness, belongs to the best qualities of human nature. . . . But it should take second place to the respect for facts. One need not be ashamed to admit it when one sets aside reliance on authority in favor of one's own judgment, gained by study of the facts.

Sigmund Freud—Wiener Medizinische Wochenschrift, 34:1889.
(Quoted by Ernest Jones in *Life and Works of Sigmund Freud*, Vol. I, p. 238.)

Present Status of Deanol as a Cerebral Stimulant

CARL C. PFEIFFER, M.D.

Considerable time has elapsed since the marketing of deanol as a biochemical stimulant. This period of time ordinarily would be sufficient to allow the medical world to form an opinion as to its efficacy. Deanol, however, is not a drug which produces rapid stimulation and after effects, as does cocaine when given intravenously. Deanol is not similar to the amphetamines which, in suitable dosage, will allow the truck driver to rumble on for 48 hours without sleep. Deanol is as slow in onset of action as are the aminoxidase inhibitors, but unlike the aminoxidase inhibitors, deanol therapy has been remarkably free of side actions.

This freedom from unwanted side actions is due primarily to the fact that deanol occurs as a natural chemical in liver and brain and also occurs in foods. Salmon eggs from the Pacific Northwest contain 2 mg./kgm. of deanol.¹ This would mean that a 25 mgm. tablet roughly is equivalent to 25 lbs. of caviar, insofar as deanol content is concerned. Deanol thus must be classified as a vital food element or vitamin (which it is) in that deanol represents a form of choline which is more readily available for the known cerebral functions of choline, which is limited in passing the blood brain barrier.

General practitioners have been reluctant to use deanol on the basis that patients must see an effect after the first dose or they stop taking the medication. By this simple criterion of drug effect patients could not be cured of pellagra or other vitamin deficiencies, and psychotherapy would be a dismal failure. The maximal effect of deanol therapy will usually be seen at the end of three to four weeks of daily therapy at a dosage level of 25 mgm. each morning. Not all patients re-

quire this relatively prolonged therapy to get results. Childhood nocturnal enuresis may be controlled as early as the third day of treatment. This has encouraged a few optimistic mothers to discontinue deanol therapy after the fourth day, but the enuresis reappeared approximately one week later.

When deanol was introduced, the original workers^{2,3} suggested that it was a slow acting stimulant which was effective in chronic fatigue, depression, migraine or periodic headaches, functional bowel distress, asthma, Raynaud's disease and schizophrenia. Have these been confirmed, and what other clinical disorders have been added?

In chronological order, Lemere and Lasater⁴ report that the amphetamines produce tension, insomnia and anorexia. Piproldol and methylphenidate have fewer side actions but are less effective in depression and fatigue than the amphetamines. The newer thyroid preparations have not been particularly helpful, while the tranquilizers seldom help and may even aggravate depression. They tried deanol in over 100 patients and found that some degree of therapeutic benefit was obtained in 70%. Fifty percent of the patients preferred deanol to the amphetamines. The only side action was overstimulation with high doses. Deanol was ineffective in severe depression. Meller⁵ found that 13 of 17 patients obtained relief of their mild depressions on deanol therapy. Moriarity and Mebaine⁶ confirm this beneficial effect in psychoneurotic depression in a group of 51 patients, where 28% had striking improvement and another 28% had moderate improvement. Schorer and Lowinger⁷ obtained some degree of improvement in slightly over one half of a group of 29 depressed patients. Settel⁸ treated 77 patients and found good

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to excellent results in 75% of acute reactive depressives and 60% of chronic involutional depressive patients. Young⁹ treated 37 depressed patients and had good to fair results in 30. Five out of six patients with chronic fatigue had a favorable response. The over-all favorable response reported by these six groups of workers is 311 patients treated with 196 benefited, or 63%.

Deanol therapy originally was advocated as basal therapy for migraine and periodic headache. Some of Meller's⁵ patients had chronic headaches which responded to this therapy. Settel⁸ obtained good to excellent results in 83% of the migraine patients treated. Young⁹ obtained good results in two out of three patients with tension headaches.

Adequate clinical trials of deanol in bowel distress, asthma and Raynaud's disease have not been completed as yet, but occasional patients have had a dramatic response.

In comparison with Vesprin the original authors³ claimed as much success with deanol in schizophrenia as with the more potent tranquilizer, Vesprin. This antipsychotic effect now has been confirmed by three independent groups of workers. Toll¹⁰ studied deanol effects in 22 schizoid patients and reports that more than one half of this group were improved. She believes deanol to be a useful adjunct to psychotherapy and other drug therapy. Pennington¹¹ tried deanol in 100 institutionalized female schizophrenics. This therapy was moderately effective in 25% of these patients who showed increased interest in their social milieu, their work and recreation. Their somatic delusional trends, depressions and mutism were alleviated. Barsa and Saunders^{12,13} studied deanol therapy in 200 female institutionalized schizophrenics who had not benefited or had plateaued in their therapeutic response to tranquilizer drugs. In occasional patients deanol alone showed a definite antipsychotic action. The large group

of 200 patients were treated for 6 to 13 months, and they concluded that deanol combined with a tranquilizer is of definite value in the treatment of schizophrenic patients. The stimulating action of deanol counteracts the depressant effect of the tranquilizer and deanol's antipsychotic effect is additive to the tranquilizer.

These reports all are confirmative of the original findings, and one should note that negative findings have not been sufficiently frequent to warrant a single negative publication.

It is always of great interest to learn of the possible other uses of a new drug which originally were not anticipated. In this category the effect in behavioral disorders of childhood is most encouraging. Oettinger¹⁴ pioneered in the use of deanol in behavioral disorders of 108 non-epileptic children. Sixty-eight per cent had beneficial effects. In at least 10 patients the results were dramatic. Some showed definite improvement in all school subjects within the first six-week grading period, and in many the ease and speed of reading was greatly increased. Ability to learn arithmetic was remarkably improved. In contrast to their previous amphetamine therapy these young patients awakened controlled in the early morning and had an increased appetite with weight gain instead of the continual anorexigenic effect of their previous therapy. Oettinger finds the optimal dose to be 50 to 100 mgm. per day. He also summarized the results of deanol therapy in 17 epileptic patients. Eleven of the 17 had some improvement in their behavior, while only three had improvement in seizure control; seven were made worse. Three of these were grand mal epileptics whose incidence of seizures became more frequent on deanol therapy. This was predicted from early clinical observations and by the fact that animals with sustained high dosage have audiogenic and spontaneous convulsions. Tobias¹⁵ has used deanol in 174 maladjusted or emotionally disturbed children.

In addition to environmental, psychological and medical aids, he had used the tranquilizers and amphetamines in many of these children. The effect of deanol has been unique in many instances and sometimes striking. The dosage ranged from 50 to as much as 300 mgm. per day. A beneficial and astonishingly good result was obtained in 108 out of 139 children who were below 14 years of age, or 78%. Self-isolating children were seen to manifest a greater interest in others. Their desire to play with other children was very prominent and was coupled by good acceptance by their peers. A number of children, initially belligerent, annoying to children and adults alike, uncooperative, abusive or assaultive, responded to deanol therapy by becoming quieter, more reasonable individuals. They accepted authority without "blowing-up" and could be reached by verbal suggestion. Several children who had flouted parental authority and even struck their mothers became respectful and cooperative. As with Oettinger's patients, these children showed an increase in reading, speech, memory and arithmetic abilities.

Case 1. One nine year old boy had been in special speech and reading class for two years without noticeable change. Having been rejected by his peers and participating in no school activities, he occupied himself almost exclusively with watching television. He was receiving thyroid extract and an anticonvulsant, although improvement produced by these agents had been at best slight. Three weeks after the addition of Deaner, 50 mgm. three times daily in the regimen, improvement had progressed so far that he was discharged from the remedial class. He began to spend his afternoons on the school playground. Six months later, he received a school award for being the school's outstanding basketball player. It is noteworthy that a withdrawal of Deaner for two weeks some months earlier had been accompanied by regression to the pre-Deaner pattern of behavior.

Case 2. A five-year-old girl, normal prior to appearance of a middle ear infection, developed a condition diagnosed as focal encephalitis. She was left with a speech aphasia and a hemiplegia. These persisted and the girl was assigned to a school for handicapped children be-

cause of her physical condition and difficulty in learning. She had had seizures, but as of February 1958, she had been free of seizures for two and a half years while receiving Dilantin. No other medication was being administered. Treatment with Deaner was started at that time. After receiving 50 mgm. three times daily for five months she was appraised as having made outstanding progress. During this period she was advanced from the kindergarten level (at the age of 7½ years) to the second grade. Transfer to a nonspecialized public school was recommended. In this patient, it was the consensus of parents, teachers, a consulting neurologist and myself that unexpected and outstanding improvement had been produced by the administration of Deaner. On two occasions regression was precipitated by withholding the medication.

In a group of 15 patients, aged 14 to 18 years, the effect of deanol therapy was only slightly beneficial.

Cotton¹⁶ has studied deanol in 38 patients in a general pediatric practice. Five patients with nocturnal enuresis were relieved of this annoying disorder within three to 30 days, after initiation of deanol therapy at the 25 to 50 mgm. per day dosage level. Oettinger¹⁴ and also Tobias¹⁵ found deanol to be effective therapy for enuresis. Cotton finds nail biting, temper tantrums, thumb sucking and nightmares are ameliorated by deanol therapy.

Finally, and optimistically, various groups throughout the country are using deanol in the treatment of mongolism. The initial effects have warranted the continuation of the therapy, but conclusions must await a careful evaluation of the results of one, two or more years of continuous therapy—preferably in the youngest mongoloids available.

Objective studies on the effect of deanol on the normal human electroencephalogram have been in progress in our laboratories during the past year. The EEG waves are rectified, and the area under each curve or electrogenesis is measured electronically. A stimulant drug will produce an alerting (arousal) response in the EEG so that the normal alpha wave is diminished or appears less often, and hence a decrease in electrogenesis appears

TABLE I

Comparative Effect on Electrogenesis of the Human Electroencephalogram Produced by Intravenous Choline, Deanol or Amphetamine in Six Subjects

(Values are in negative percentages from the control period.)

	Time After Injection (Minutes)				
	5'	15'	25'	35'	45'
Choline	7.2 ± 2.4	3.0 ± 1.5	7.1 ± 2.9	4.5 ± 1.7	2.5 ± 1.2
Deanol	9.8 ± 3.9	7.9 ± 3.4	8.5 ± 4.5	20.2 ± 2.3*	13.2 ± 5.1†
Amphetamine	14.2 ± 4.0	11.5 ± 4.8	20.8 ± 3.3*	20.7 ± 2.6*	16.5 ± 3.4†

*Significantly different from choline p=0.001

†Significantly different from choline p=0.05

‡Significantly different from choline p=0.01

in comparison to the control baseline.

Characteristically in both the rabbit and in man intravenous deanol does not change electrogenesis until after a 30-minute latent period. Amphetamine, however, has a stimulant effect within the first five minutes. When these studies are completed, we should have incontrovertible objective evidence of the stimulant effect of deanol in man.

A summary of our data to date on six subjects is given in Table I. These subjects were injected intravenously in a randomized experimental design with 1 mg./kgm. of choline chloride, 1 mg./kgm. of d-1 amphetamine as the sulfate salt and 1 mg./kgm. of deanol.

The choline is inactive. The deanol effect appears 35 minutes after the injection, while the amphetamine effect appears in five minutes. Behaviorally the subjects felt stimulated and less sleepy with amphetamine and deanol but not with choline.

SUMMARY

The present status of deanol as a cerebral stimulant is summarized. Six publications confirm the value of this therapy in psychiatric depression. Three publications confirm its action in alleviation of various types of headache. Three groups of workers substantiate the usefulness of deanol therapy in schizophrenia and the schizoid states. Quantitative studies on the electroencephalograms of normal human volunteers show that a significant decrease in electrogenesis occurs 30 minutes after an intravenous injection of 1 mg./

kgm. of deanol. A similar alerting response occurs within five minutes after 0.1 mg./kgm. of d-1 amphetamine, but the action of 1 mg./kgm. of choline is insignificant. The reports of other investigators support the findings of the earlier investigators.

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The Historic and Philosophic Aspects of Anxiety

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Our epoch has been glibly called an Age of Anxiety, yet the anxiety of Western man is as ancient as history. His story, a tale of little hope, bad health and great insecurity begins many millennia ago. It is only in recent times that society has made some effort to help man overcome his feelings of anguish, despair and alienation.

The main purpose of this abstract is to examine some of the historic and philosophic aspects of the contemporary human predicament and to explore some of its solutions.

The Greco-Roman Solution

The ancient Greeks had two modes of relieving anxiety, the Dionysian and the Apollonian. The Dionysian, which was practiced by the masses, sought to disintegrate the personality into its demonic aspects. It tended to relieve pent-up feelings with wild outbursts of expressive behavior. The apparent purpose of the orgiastic rituals was to provide for catharsis of emotions. The Apollonian method, propounded by philosophers, and practiced by the elite, sought to integrate personality through reason and education. Socrates, Plato and Aristotle believed that the keynote to a happy life is to know one's self. Following the Hippocratic tradition, these Greek philosophers urged that man practice virtue in the manner that man may become healthy by following the laws of nature. The cardinal virtues of the Greeks were courage, temperance, wisdom and justice. The practice of these goals would result in man's achieving a happy life.

During the marked social chaos that

followed the Hellenistic period, a number of philosophic solutions were offered to alleviate the distress. Of them, the Stoic solution, has remained as a permanent tradition of Western man, with some modifications, parading under different banners in each era. The Stoics understood philosophy as the practice of the art of living. Its aim was virtue; only the virtuous could survive the vicissitudes of fate. Stoicism provided a strength of purpose. It helped man to accept his fate, but by his own choice.

Medieval Man and the Christian Solution

Medieval Christianity was born of the need to relieve the misery of the masses. It brought love to the humblest, hope to the downtrodden and relief to the despairing; illuminated a period filled with despair, hopelessness, meaninglessness and alienation. Our own period is one of Augustan calm compared to those years of human misery. The dark ages was an era of panic and desperation, the peasant revolts, the dancing epidemics, the brutal extermination of the Albigenses were all signs of pent-up emotion released into collective hysteria.

The Ethic of the Middle Ages called for passive conformity and unqualified acceptance of authority. Deviation was heretical and punishable by hideous death. In spite of the hedonistic overtones of chivalry, the gaiety of festivals, the delights of courtly love and the "gamesmanship" of knighthood, the idealized embodiment of medieval man was a monk covered by a black cowl. He lived ascetically away from the world, in poverty, hardship and prayer. The poor thought of themselves as children. Any tragedy was punishment for not conforming to the rules; if they carried out the regulations, the heavenly powers would protect them.

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While Christianity brought solace to some and privileges to others, social and economic systems kept evolving into more complex dynamic national units. With the decay of the feudal system, man was catapulted into a world without stability. The fervor of the Crusades was frequently transformed into mob violence of the vilest sort with invading armies seeking treasures, pillaging, raping and murdering in the name of Christ.

The Renaissance Solution

During the imperceptible transition between the Medieval Period and the Renaissance, problems mounted as the static city-state culture disintegrated into the more complex nationalism. The internal revolt within the Roman Catholic Church split Western Christianity into two groups, the Catholic and the Protestant with resultant ideological insecurity.

New continents were being explored and exploited. Plagues, among them syphilis, ravaged Europe recurrently. The King's authority was gradually superceding the power of the nobility and Parliaments. Artists broke with the medieval tradition, developing the ebullient individualism of the Renaissance. When the printing press spread reading knowledge to the humblest hamlets, literary men met this challenge by writing in the vernacular. Among the foremost writers were Dante, Petrarch, Machiavelli, Boccaccio, Bacon, Shakespeare and Montaigne.

Montaigne, who played the part of the leading moralist, transcended the limitations of his era. He was a Renaissance man in the Stoic tradition. After being embroiled in the savage political and social life of the Renaissance, he reacted to his own anxiety and retired to his library tower. His recorded essays became one of the greatest monuments of literature and philosophy. Montaigne preceded Freud by three centuries in the use of self-analysis for self treatment. He foresaw the psychosomatic concept; anxiety seemed to be part of man's existence and neurotic anx-

iety part of each individual's life pattern. Like the Stoics, he believed that irrationality was a disease and that the main purpose of man's philosophy was to teach one how to live.

The Protestant Ethic, Puritans And the Scientific Revolution

The individualism released by the Renaissance emerged into a number of new world-views. Luther challenged the sovereignty of the Roman Catholic Church. Calvin developed Protestantism which later became the dominant world-view, reflecting the changing social, economic and political systems. The Protestant ethic was a world-view that reinforced values, sentiments and beliefs of self-reliance, independence and enterprise—all of which would help the ascent of the middle classes. The characteristics it cherished were those of a man of action with strong motivation, freedom from social preconceptions, self-confidence and the foresight that leads to individual initiative. Extreme Protestantism held all pleasure suspect, but canonized church going, hard work, large families.

The Solution of the Enlightenment And the Eighteenth Century

The modern era began with an explosive mixture of the Apollonian and Dionysian forces of history. Man lost his former ideological landmarks and anxiety pervaded his being. His search for identity became crucial. Pent-up emotions, reflecting the turmoil of the period, erupted into mob violence.

The *philosophes* became spokesmen for the bourgeoisie. Among them were men of action, science and letters, such as Voltaire, Diderot, Condorcet, Goethe, Adam Smith, Priestley, Benjamin Franklin and Thomas Jefferson. Their dogmas were based on humanitarianism, their faith was in science, that through reason, man would master his own destiny. Unwittingly, they whipped up the Dionysian forces that erupted in the frenzy of the French revolution.

lution. When the superstructure of France toppled, the Jacobins gained control. They expressed themselves through mob violence and the apocalyptic fervor of early Christianity. Their brief and bloody era ended in dictatorship and the rule of Napoleon. Through conquest, he carried the concepts of the Enlightenment throughout the West, establishing them as law in the Code Napoleon. After the smoke of many battles cleared, liberalism, child of the Enlightenment, had carried the bourgeois revolution into the most distant corners of the globe.

The Nineteenth Century Solution

The nineteenth century, the beginning of the modern era, resembled a simmering cauldron of multiple ideologies. The old creeds, now modified, appeared under new labels. Prodded by industrialization, the Enlightenment world-view evolved into modern liberalism. After many vicissitudes, its ultimate creed became democracy. Its mainstay concerned itself with the dignity and freedom of the individual from authoritarianism. Its corollaries were democratic voting, universal civil rights, equality before the law and the protection of the individual from external power. The highest purpose was for social and economic security; its ultimate, the achievement of the welfare state. Secularization, industrialization and urbanization with the resultant technological advances, brought social disruption. Public transportation destroyed the tranquility of the countryside. Cities were crowded with explosive problems. Darwin and Marx came forth with the two pervading ideologies that influenced the course of history.

The 19th century doctrine of the Economic Man stemmed from the high-minded liberals, socialists and Marxists. Their dehumanized belief was that man is an organism engaged in the production, distribution and consumption of wealth, a consumer of products. Without consumer-ship, man loses status; unemployment,

starvation and despair would occur. Human progress will occur only if man discovers the perfect economic system.

The ideals of the 19th century expressed themselves in the Victorian behavior, a modern modification of Puritanism. The Victorians underlined respectability, conformity, and guilt. Their moral goals, like their furniture, were more solid and stable than spiritual. Their values well suited enterprising business men creating an industrial era. At their best, Victorians practiced thrift, hard work, cleanliness, self-restraint and self help. At their worst, they were greedy, smug, frigid and dull. In spite of the external tranquility of Victorianism, their century was turbulent; the masses lived uprooted lives. Helped by middle class encouragement, medicine, public health, physics, chemistry, biology and engineering soared to unheard of heights. A reaction against this scientific revolution expressed itself in the romantic protest.

Rousseau had already set the pattern of neurotic subjectivism in his writings. The Marquis of Sade added his obsessive thinking concerning sexual pathology. Two modern literary trends stemmed from these concepts; one a drift towards expressive subjectivism and individualism, the other a social movement of epatism. "Epater le Bourgeois" (stamp on the middle class). This emphasis on the non-rational in life appears in the literature of Kafka, Baudelaire and James Joyce; the philosophy of Schopenhauer, Nietzsche, Freud and Heidegger; the painting of the impressionists, expressionists and abstract expressionists. The type of individualism that created millions of heroes and heroines all involved in a romantic agony helped spawn the modern Western world's obsession with sex and mental illness.

The Freudian Solution:

Psychological Man

Freud's version of the Psychological Man follows in the Stoic tradition. His

concept of personality was influenced by the nineteenth century's scarcity economics. He believed that the self was continuously being threatened by the fear that the psyche would run out of energy. Freud exposed the conventional beliefs of human society, relegating religion to a delusion. Each family relived the Oedipus myth, with hatred for the father as its keynote. Virtue originated from infantile needs and was associated with excrement. Initiative, orderliness, parsimony, cleanliness and hard work were reduced to anal gratification. Life was a triangular struggle between the Id, Ego and Superego. Women suffered from penis envy and castrated men when they changed their passive role. All behavior could be reduced to reactions to pleasure and pain; all curiosity and creativity to gratification and need; all thinking to rationalization and irrationality. Freud's beliefs were a form of epatism, attacking middle class morality. What Freud was really saying was that the true portrait of man is that of a non-rational, half-sick animal, consisting of degraded and perverse impulses. Civilization was a man's trap; a trap that created perpetual illness. Man's existence was meaningless; the most he could do was come to terms with his anxiety by grappling with self-knowledge on an analyst's couch. While he waits his turn to die, let him search out his guilt and anxiety and face what he must with psychoanalysis.

In brief, Freud's credo was to teach how to live without belief, without health and without significance. His main contribution to culture was to open up new avenues to psychiatric investigation and treatment. His main weakness was to derogate man's strivings to transcend his Self.

The Alienated Man and The Existential Solution

The twentieth century's problems accentuated man's perplexity. Many world-views shattered the middle class's complacency and crowded its consciousness

with emotionally charged preoccupations. Unemployment decreased; the welfare state built in economic stabilizers. The growing wealth of the masses helped create a democratic society. Nationalism created destructive, mechanized weapons.

Hegel was the first to observe modern man's alienation. He assumed that reality is primarily spiritual and related man's estrangement to the alienation of his mind from itself. Karl Marx strongly opposed Hegel's idealism. He accepted the fact that man was alienated—but by class struggle. He believed that after the bourgeoisie was overthrown, man's alienation would cease.

Existentialism rose in opposition to the industrial revolution and the mechanization of Europe. Challenging both idealism and materialism, the existentialists perceived today's predicament as one of loneliness, anxiety, death and despair. The alienation of contemporary man was prophesied in the writings of Kierkegaard and Nietzsche, Dostoyevsky, Rilke and Kafka. Picasso and his school painted man's impoverished soul. Tennessee Williams and O'Neill revealed his empty life. The leading German philosopher who attempted to solve the crisis of our time is Heidegger. His solution was to philosophize, using "fundamental ontology." With this method, one could experience authentic Being. A group of European psychiatrists fused Heidegger's concepts of recall thinking with modern psychiatry. Using the phenomenology of Husserl and Jaspers, they left science for a metaphysics that they believed brought them closer to the human reality.

French existentialism was born out of the experience of World War II. It was created by Sartre and his colleagues who borrowed their phenomenology from Husserl, their ontology from Heidegger and their philosophy from Nietzsche. Their main contention was that man is alone in the universe. His life is meaningless and his only solution to transcend the human

situation is by becoming *engage*. The human predicament, they believed, was created by the Enlightenment and its handmaidens; progress, science, reason and technology. Their vigorous opposition to reason in all its forms promoted their belief in action arising deep from the "unconscious," in "passion" and in the "will." When it came to political belief and behavior, some of the leaders of secularist existentialism briefly became Nazis or communists, proving that philosophers like others can be both fools and dangerous to humanity. Frequently, existential beliefs and social behavior gave one the eerie feeling that we were dealing with a collective form of schizophrenia.

Existential thought was familiar in Judaism and Christianity for over two thousand years. The subject matter of the existential philosophers, such as the alienation of man, the anguish of the human situation, man's knowledge of death, loneliness and despair have been the preoccupation of religious philosophers for centuries. This way of philosophizing was familiar to Plato and Socrates a thousand years before Descartes, the industrial revolution, the Enlightenment and the worship of progress.

Existentialism inspired much rethinking on man's present predicament, but it never reached an adequate formulation of an ethic for our contemporary crisis. It did chasten the liberal's belief in Reason. It made liberals aware of the limitations of Reason and democracy and it underlined the ever-new dangers created by progress itself. Thus far, it is too abstract, too highbrow, too religious and too disturbing a concept. From all present indications it appears that by creating a loathsome picture of man through literature, painting and philosophy, he has estranged himself further from his roots by the self-fulfilling prophecy.

Introduction to a Unified Approach to Man

The questions raised by the existentialists compelled all future thinkers to heed man's alienation, loneliness, anxiety and despair. Modern thought destroyed many naive Victorian beliefs in the automatic evolution of man, in the omnipotence of science, rationalism and man's natural goodness. Western literateurs joined the fashion with their down-grading of the accomplishments of modern man and his democracy. Literary mugwumps like Yeats, T. S. Eliot and Ezra Pound helped to further alienate the intellectuals from the masses, preaching nihilistic, fascistic or theocratic solutions. Social liberalism became the general Western world-view after World War II. When Europe, following in the footsteps of America, extended democracy and the welfare state to all men, the common man was secure for the first time in history. With government protection of the poor, poverty was diminished. The aged and infirm were cared for and benefits of public health were extended to all. A college education was becoming a common experience. The general public was becoming involved with the arts and sciences. The over-all picture was much better for the general public than it had ever been in the history of mankind. There was some hope that the disease of nationalism would eventually be cured by some supra-national state of all mankind.

The United Nations was created to settle international disputes that threatened world security. Theoretically, the organization of states could prevent war and enforce peace, a dream of all utopians. In spite of international hypocrisy and competing nationalisms, some progress has been made. The idea of world peace has been more firmly implanted as part of our expectations.

Influenced by the social milieu of a society undergoing breathless change and by political science, economics, sociology

and psychology of the time, such behavioral theoreticians as Rank, Adler, Horney and Sullivan ventured to offer a new framework to meet man's contemporary problems of alienation. The most eloquent of this group is Eric Fromm, whose background in history, sociology, philosophy, psychoanalysis and Marxism suited him for the role of prophet and moralist of the new evolving world. Fromm believes that life's meaning is created by the individual himself who unfolds the potentiality of his powers of reason, love and productive work. This unfolding and realizing of his potentialities constitutes the basis of man's happiness and salvation.

Man's strivings cannot be explained by the nature of his instincts, according to Fromm. When his needs for food, drink and sex are satisfied, he may then strive for power, love or destruction. He may risk his life for religious, political or humanistic ideologies. These strivings after meaning are what characterize the uniqueness of the human personality. Fromm's solution suggests we change our capitalistic system, suppress our bourgeois culture. He represents the Jacobin world-view, modified by psychoanalysis and existentialism. His world-view represents a solace made up of emotionally charged words, reducing our anxiety in the tradition of the Stoics.

These new moral philosophers of the twentieth century have not improved on the clear and bright picture of human nature offered by Montaigne. They have only used the new, fashionable language of scientism bringing it closer to our contemporary understanding. The Stoic solution has only been modified; new labels have been found for old problems.

There is now a race between communism and democracy to see which ideology can promote science and technology for the utmost good of mankind. When it comes to understanding man, his environment and the promulgation of scientific solutions to man's social problems, both democracy and communism are dragging

their feet. In social democracies, permissive criticism and personal decision-making create an atmosphere that permits scientific undertaking. The communistic regimes permit scientific inquiry that supports their current interpretations of dialectical world-views, thus preventing scientific inquiry of our total human predicament and its solution.

Throughout the scientific community there has developed an inter-disciplinary approach springing out of pure necessity from the late war. Physicians, chemists, engineers, physicists, biologists and mathematicians have become accustomed to working together, finding ways of inter-communicating. The results of this multi-disciplinary approach have been extremely fruitful. In the behavioral sciences von Bertalanfy, Grinker and many others began to utilize the unified methods of many disciplines to solve man's problem of understanding himself and his environment. Scientists are now in a preliminary stage of creating a new technique of solving behavioral problems.

Included with sociologists, psychiatrists, physicians, pharmacologists, psychologists political scientists and others, there is usually a moral philosopher. This philosopher represents the conscience of man. He carefully watches to see that the scientists do not become obsessed by demonic forces hiding somewhere in the laboratory ready to destroy man with Dionysian abandon. In the multi-disciplinary approach lies all of our hope for the future. No one man has the great vision necessary to see all aspects of the problems confronting humanity. Our society is now too complex, too pluralistic to rely on intuition alone or the oracular insight of sages. The Stoic solution can give us hope and solace, but it is on science that we must rely for the method, the approach and the wisdom. Man has not yet touched his potentialities for living well. In the future, this hope may be attained.

The Physician as a Therapeutic Agent

GEORGE J. TRAIN, M.D.

INTRODUCTION

In this period of materialism, technology and analysis, it is appropriate to examine the doctor-patient relationship with emphasis on the physician himself as a therapeutic agent. Medicine has grown tremendously through scientific advances. Yet, in common with antiquity, its practice remains steeped in interpersonal harmony. Hippocrates pledged us to observe the rights and dignity of patients and also noted that recovery may occur through "contentment with the goodness of the physician."¹ Paracelsus confirmed this observation with: "all I can give my patient is love, while Ambrose Paré observed with humility: "I dress the wound and God heals it."

But something has gone awry. A "therapeutic paradox" exists. In "an age of medical miracles almost beyond belief,"² the doctor-patient relationship keeps deteriorating to new lows. Fewer students desire to study medicine and the physician finds himself struggling to maintain his once respected social position. If the family doctor is to survive, he must master personal medicine, concludes a British physician.³

While the problem of interpersonal relationships is not new, its analysis is. In this paper I wish to add to the discussion of the dynamics of the patient-doctor relationship and to focus attention on the physician himself as a therapeutic agent.

THE PROBLEM

The Patient:

The personalities of both the patient and the doctor as principals contribute to the dynamics of the doctor-patient relationship. Medicine is a skill based on the

physical sciences, to be applied by a trained person with emotional needs, to a layman with his emotional needs, cooperation and judgment. This skill necessitates a measure of humanism, intuitive or learned, as the vehicle for its expression. Indeed as Dr. Askey⁴ pleads: "the principles of psychiatry (which studies humanism) must be emphasized as working tools in the practice of medicine."

In a harmonious relationship, the patient meets with the doctor for treatment to eliminate pain, or to adapt to permanent disability, or for means to ease his last breath. His need for both physical and supportive care is dealt with effortlessly by the gifted physician who renders his skill to terminate his task with mutual gratification. A poor patient-doctor relationship, however, is trying and may prove disastrous to both participants.

The patient-doctor relationship is a complex involvement of psychological and cultural influences in the personal lives of both participants. The patient suffers pain, a signal of disturbed homeostasis. This excites fear and disrupts ego control, reducing its effectiveness in keeping repressed the contents of the unconscious which constantly seek the final common pathway for expression. Energy—narcissistic libido—is essential to ward off this threat; in the process of attempting to maintain repression, a variable quantity is necessarily withdrawn from the ego for this purpose. Moreover, the loss of libido affects the capacity of the ego to carry out its duties in connection with reality. Thus pain and fear induce the threatened return of the repressed and ego deprivation. To protect itself, the ego unconsciously develops defenses against unconscious contents by erecting a wall of anxiety. Other ego defenses may also be necessary. A patient with pain and fear re-

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gresses to an earlier infantile level to eliminate distress. He falls back on that previously successful level in which the parent-child relationship sees the mother as omnipotently capable of mastering perilous reality by will and manipulation by magic. This relationship finds him dependent and receptive, with a craving for parental "love."

Unfortunately for the patient, however, earlier levels also contain inner conflicts and fear which revolve about helplessness and the threat of abandonment and death. So it was that a short-story writer, working to meet a deadline, smoked and ate incessantly, but also smelled the hospital where he had left his appendix. Sure he can have "momma" to provide him with strength and wisdom, but beware the price of incest. Hence his "writer's cramp," his impotence, his marital discord, his episodes of depression. In addition, the patient may recall a later episode in which his mother expressed hostility when she learned of his illness: "God bless you—long may you live!—you have sneezed," developed with the third sneeze into "Go to hell, you have a cold." Father's complaint about his son's illness: "All I do is work for the doctor," further intensifies guilt feelings.

The defense of denial of the existence of disease in terms of "it doesn't hurt—it's nothing—I'll be all right" is also used and it delays consultation with the physician. This occurred with a well-educated, biologically trained, intelligent, sadomasochistic patient who ignored hematuria for seven years before he mentioned it casually to his doctor friend. This is another example of paying tribute to severe guilt feelings, which are eliminated only through suffering. These positive and negative attitudes—ambivalences, are transferred to the physician. He becomes at once the healing, magical figure, which endowment is the source of some of the doctor's power to relieve suffering, and is also feared and hated. The defense of

projection, since it consists of blaming the next fellow for one's own feelings, thoughts and acts, may cause the doctor in serving his patient to become the object of wrath. Along with these ego defenses are signs of ego failure evidenced by intellectual impairment; perception is blurred, reason and judgment are defective, communication is awkward.

The antidote for this syndrome of pain, fear and the manifestations of the return of the repressed, e.g., anxiety, dependency and other defenses, is love, a complex biopsychosocial phenomenon which the gifted doctor provides with ease. It neutralizes anxiety and restores homeostasis. Love is rooted in the act of satisfying hunger which is represented in the mental mechanisms as "milk of human kindness." Through love, the ego is supplied the narcissistic energy needed to enhance self-esteem and re-repress the unconscious. Love is the healing stuff which research must help us to understand. A "Flight into Health"⁵ results and natural mental healing properties are freed.

In passing, it is well to remember that this process is no cure in the concrete sense it is meant to be. The inner conflict has not been expelled but remains to reappear on another stress occasion with perhaps greater severity. But with a healthy response to love, the relatively mature ego reappears with narcissistic supplies. The patient adapts to his illness and cooperates with the physician for a successful conclusion. But when the patient's character is unable to draw on the love provided by the doctor, to neutralize anxiety because of his own difficulties, or the doctor's, he evinces hostility. The doctor becomes a "butcher," a "sucker," a "money grabber," a "quack," and the patient may threaten with a lawsuit, as seems to be evident more and more today. It is well to remember that a patient may have a compulsive need to announce his suffering to the world to accomplish unconscious expiation and to trap his doctor into ir-

nocent complicity. In addition, each patient has an unconscious concept of the meaning of his illness which determines what he is to suffer, how long, and by what means and who shall make him well. Oftentimes in this period of medical miracles, the patient may resent the doctor because he became well too soon and had to return to the slings and arrows of reality. One should also note that the need of the patient for the specialist, the busy doctor or the institution doctor; of others for the spiritual guide, and others for the quack, is no accident. Its source is traceable to unconscious needs.

Cultural influences also make their appearance as the patient consults the doctor. Briefly stated, this is an age of faithless irreverence and contempt for tradition, with devotion to materialistic sensualism. It is "Hi Doc," the chummy first name calculated to level us all with an eye to the quick buck and luxury living. A bright but troubled teen-ager was enlightening when he said, in answer to my question as to why he calls me by my given name: "If I call you doctor, I'm a nobody; if I call you 'George,' we're equal." This attitude compounds the negative features of the transference and the doctors are referred to, with the help of Hollywood and other commercial media of communications, as the "head shrinkers," "butchers," "mad scientists," and the like.

The Doctor:

And now, the doctor, how does his personality contribute to the success or failure of the interpersonal partnership? What determines his adequacy in practice? Prominent are the factors of motivation, training, overwork and his tendency towards denial of disease. Motivation is strongly linked to sexual and sadistic impulses, the desire for prestige, and to help a fellow human being. A doctor patient who consulted me because he cannot say "no" to numbers of patients is given to work "48 hours daily." He revealed a chaotic marital relationship. He

resolved to study medicine because of the sexual intimacies he fantasied when his mother was closeted with her physician. He desired to identify with him and experience the same privilege. Of course, the motivation goes more deeply, but this is sufficient to illustrate problems which promote certain types of behavior. Repressed associations of anxiety, hostility, guilt and punishment are associated with biological impulses, and tend to appear in the face of frustration. The reaction that follows is similar to that of his patients to pain, as described above. Defenses of the same ilk are developed by the ego for protection against the return of the repressed. Lest his sadistic impulses find free flow, a psychiatrist with severe and repeated gastric distress suffered somatophobia which influenced him to reject physiogenic therapies and protest volubly against even hand shaking with a patient.

Moreover, the doctor's training can be confusing. The crowded medical curriculum with more emphasis on laboratory tests at the expense of bedside practice, with its justifiably deep concern with the development of skills in pathophysiology, oftentimes refers to psychotherapy with contemptuous mention. One study indicates that the largest proportion of physicians questioned complained that "practical instruction in the doctor-patient relationship" was most deficient.⁶ However much we may protest, a contradiction does exist between science and the humanities. As Erasmus' appraised, the "superstoic Seneca (who) strips the wise of absolutely every emotion . . . (and) leaves . . . a marble imitation of a man . . . alien to every human feeling," so science warns students to objectivity, not to trust the senses; that experiment is fallible, to search for objective tests, etc., betraying an exclusive concern with disease and not the person. Humanism is the step-child that just shuffles along in the medical curriculum. That medicine is more than skill is evident to the attentive student. To

complicate matters, he must correlate with physical medicine the remarkable curative "effects of the power of suggestion, the wish to believe, cures by placebo, Hippocrates' "contentment with the doctor's kindness," and the need for doubleblind tests in research. He learns that psychic distress may "initiate, aggravate and perpetuate" somatic symptoms,⁸ that the importance of the psychogenic is undisputed in the female's sex response.⁹ He rightly asks how shall I minister to the needs of the post-partum depressed patient who protests: "I hate my role in life, but this I must be, a mother and a wife."

Whatever his motivation and training, the pressure of work must wear on his own narcissistic ego reserves. Demanding patients, night calls, long hours, interruptions of normal family life, financial problems, service without reward, professional competition and the need for acceptance, all contribute to frustration and overwork. Success in dealing with these burdens maintains ego esteem and leaves the doctor free to work effectively with his patients.

The Response

With the knowledge that illness makes the afflicted more sensitive, easily offended, less tolerant and quite capable of sensing generally whether the physician likes or dislikes him, the doctor is careful lest he commit irreparable errors of rapport. With awareness, the physician is apt to be less the technician and more the understanding, supportive, genuinely concerned skilled person who is a source of that "milk of human kindness," the antidote which neutralizes anxiety and fosters the development of rapport. Being relaxed, he can listen. With trust and confidence, he is able to get to the physical problem at hand. Certainly he is no jellyfish, and he goes about his task with assurance, further allaying anxiety. Mutual narcissistic gratification follows, the patient taking "flight into health" and the doctor a flight into egophilia.

Failure, however, stirs frustration, anxiety and egophobia. The doctor regresses as his patient did, and suffering egophobia, develops such defenses as arrogance and cold aloofness like the cardiologist who scolded the convalescing coronary patient for coming late, yet insisted that he eliminate egg yolk from his diet if he is to survive. The physician may become unreasonable, authoritative, easily aroused sexually, or blocked and anxious in examining the female. He may be psychophobic or somatophobic, unable to recognize his own anxiety and that of his patient, and depend excessively on drugs and instruments. Indeed he may take to prayer: "Lord, all I ask is sense to flee, from folks who need psychotherapy. Let somatic ills keep me employed in general practice, un-a-Freud."¹⁰ But Hollister¹¹ would remind him: "There is no drug yet known which will remove a patient from a stressful environment or influence human behavior and thought as much as persons and ideas do." This admonition does not question the proper use of drugs—it merely directs attention to tools which have been sorely neglected.

Indeed, while the "milk of human kindness" is an indispensable vehicle for the application of medical skills, it is no substitute for it. Applied improperly, it may obstruct the doctor's skill if he identifies with the patient. For example, an unmarried schizophrenic patient of excellent breeding and of child-bearing age, complained of amenorrhea to her friend and doctor. Not the faintest suspicion of pregnancy arose; both suffered denial and the diagnosis was left to another physician and made well beyond the first trimester. A sorrowful course followed.

Finally, one must include in the effect on interpersonal relationships, the extension of the doctor's personality through his office personnel and decorations, other patients and perhaps of greatest importance, his wife in her social intercourse with patients. The responsibility of re-

ceiving the patient is obviously great, and a warm, friendly atmosphere is of paramount importance.

RECOMMENDATIONS

To round out his skills in dealing with interpersonal problems, to develop the awareness necessary to minimize if not eliminate distressing patient-doctor relationships, the physician should avail himself of existing facilities for which this Academy is an example on a national scale. On the local scene, physicians should meet with psychiatrists to discuss these problems either individually or in groups. This type of educational program has been initiated in Brooklyn, with satisfying results.

SUMMARY AND CONCLUSIONS

An analysis of the patient-doctor relationship has been presented with appropriate examples. The thesis is presented that the practice of medicine consists of the application of a scientific tool with humanism as the vehicle. The patient consults the doctor for relief of pain. Pain excites fear and both impair ego controls with the result that unconscious complexes are released. To protect itself from the return of the repressed, the ego erects defenses of anxiety, regression, denial and projection. The patient seeks "love" from his physician for relief. Whether the doctor can provide "love" is dependent on his motivation, training and personal problems. If he lacks humanistic qualities and relies upon objectivity to heal his patient, the physician denies himself and his pa-

tient a tremendous source of therapeutic effectiveness and satisfaction. In addition to thumping the chest, he must be the wise, comforting friend. Studies of the patient-doctor relationship should attain the recognition of a well-defined, predictable and orderly understanding and method to be taught to all physicians for easy communication with patients. Interpersonal awareness and its proper use will operate to raise the status of the doctor to a level commensurate with his remarkable scientific achievements and enhance his personal satisfaction and therapeutic effectiveness. Recommendations for education in this area are presented.

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Narcissism: He who looks at his own navel looks straight into hell.

Buddha

(Quoted by Karl Menninger, M.D., *A Psychiatrist's World*, Viking Press, p. 98.)

Some Clinical Observations with Chlordiazepoxide in Depression Associated with Somatic Illness

OSCAR F. DAVIS, M.D., PH.D., CHARLES BECK, M.D., ALAN CHARLES, M.D.,
MILTON BERGAL, M.D., and BERNARD HORWITZ, M.D.

In medical practice the clinician is constantly confronted with evidence for a personal role that influences the course and tenure of disease and the patients' reactivity to drugs. In psychiatric illness and in those areas of general medicine with an obvious psychological accoutrement, the role of the therapist is even more demonstrable but harder to quantitate.

When pharmacological means are employed, particularly drugs acknowledgedly used for their psychoactivity, identification of the nuclear source of therapeutic success is exceedingly difficult. Indeed, in illness with some psychological factor, the search for the definitive therapeutic drug seems to derive from the wish for a panacea-cure.

In evaluating drugs to determine their exact role and to differentiate pharmacologic from transactional response (i.e. reaction to physician and total milieu) one must also consider the meager specificity with which drugs are characterized. This paucity of understanding of the mechanism of drug action seems particularly true of psychopharmacological agents.

When one adds to the aforementioned area of unawareness, our present-day modest knowledge of psychiatric mechanisms, the hazards faced in clinical investigation of psychopharmacological agents is readily apprehended. For the most part, we are limited today to sound controlled clinical judgment, pharmacodynamic studies in the animal and biometric analysis.

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In spite of these inhibiting forces we were encouraged by the stimulating and exhaustive pharmacological and toxicological data observed with a newly synthesized chemical, chlordiazepoxide¹⁻¹⁰. The pharmacology of this drug encouraged its consideration as an antidepressant. Unlike phenobarbital, chlorpromazine and meprobamate, chlordiazepoxide produces a taming effect in monkeys before the ataxia-provoking dose is reached. It is an anticonvulsant (like phenobarbital) but does not produce true hypnosis (like chlorpromazine, meprobamate and phenobarbital) or depress the autonomic nervous system (as do chlorpromazine and reserpine). In addition, animal studies show that chlordiazepoxide is an appetite stimulant of considerable potency.

This communication is based on our experience with this compound when administered to patients with moderate depression associated with proved somatic illness.

Material and Methods

Patients who were depressed were selected from several categories, based on diagnosis of somatic disease.

Diagnosis of depression was restricted to those patients who had hitherto functioned within the confines of "normal" and whose psychological duress seemed directly related to the exogenous force of somatic illness. Extensive psychiatric interviewing was not undertaken; but, differentiation of test objects was attempted by excluding patients with any psychiatric history or with obvious psychotic or disabling neurotic propensities. Patients with acute precipitating personal foci also were removed from biometric considera-

tion of results, but in this regard one must consider the evidence in support of a psychological anlage or factor in organic pathology.

Thus, we attempted to establish a somatopsychic group; in particular, a study of depression. The difficulties in this selection are legion, even under rigid psychiatric procedure; and, some of the criticisms obvious. We were guided, nevertheless, by the need in routine medical practice to recognize somatopsychic depression (especially depression with agitation as opposed to inertia) and the wish to be of help to the total patient.

It is in this area of moderate emotional upset directly related to organic illness that pharmacotherapy seems best to play its adjunctive role.

Patient groups were organized according to the following clinical entities:

A. Cardiovascular-renal	135
(hypertension, chronic nephritis, post-infarction, cardiac decompensation, cardiac asthma)	
B. Gastrointestinal	60
(peptic ulcer, regional ileitis, ulcerative colitis)	
C. Gynecological	30
D. Surgical	30
E. Miscellaneous	50
(hepatic, orthopedic, hematologic, etc.)	
Total	305

The psychological response to chronic illness, e.g. hypertension, is undoubtedly different in quality from the acute reaction to impending surgery or the retrospective response to catastrophic surgery with obviously severe implications (e.g. carcinoma). By utilizing both, the treatment spectrum was enhanced and our clinical impression was broadened, although obviously not complete.

A control group of patients was treated with 400 mg. of meprobamate q.i.d. and a second control was formed with 10 mg. of methylphenidate (Ritalin^{T.M.}) q.i.d. as the treatment. The dosage of chlordiazepoxide used in this study was 10 mg. q.i.d.

RESULTS AND DISCUSSIONS

Within the confines of the strict limitations previously set forth and the difficulty of extrapolating animal pharmacology to human affairs, we feel the bulk of clinical evidence is more than suggestive or fortuitous.

It is our collective clinical impression that much of the amelioration of depression noted was associated with chlordiazepoxide therapy. An ongoing analysis of transactional data was not undertaken, but the timing, quality and quantity of changes does not appear to be a transactional or chance result. This seems particularly true when compared to meprobamate and methylphenidate.

TABLE I

Influence of Chlordiazepoxide in Depression Associated with Somatic Illness

Somatic Pathology	No. of Pts.	Treatment		Response After Therapy				
		Chlordiazepoxide	Meprobamate	Methylphenidate	Marked mood Elevation	Moder. Mood Elevation	Indiff. Resp.	Untoward Reactions*
Cardiovascular-renal	135	105	16	14	68	16	21	4
Gastrointestinal	60	40	10	10	31	5	4	2
Gynecological	30	30			6	2	2	1
Surgical	30	30			5	3	2	1
Miscellaneous	50	50			21	3	6	0
					19	4	7	0
					35	7	8	1

*Untoward side reactions were:

- chlordiazepoxide - ataxia
- meprobamate - ataxia, heightened depression
- methylphenidate - agitation, restlessness, insomnia

In 79 per cent of the cases treated with chlordiazepoxide (Table I) we were impressed with some change for the better. A change that we do not think (unfortunately, we cannot set forth conclusive evidence) was consonant with the natural history of the disease or a result of some

change in total milieu, or due to other drug therapy.

Because of urgent need, in 50 cases other drug therapy was not excluded during the course of the study (30 cardiovascular, 8 hepatic, 12 gastro-intestinal). In these cases the drugs used were digitalis, methantheline, or other parasympatholytic G.I. drugs, antibiotics and vitamins. We do not feel that these seriously mitigate from the appended results in these fifty patients and have included them statistically.

Examination of data by biometric means (Chi square, probit analysis, probability) corroborates our impression that the results did not fortuitously obtain and encourage the recommendation for further clinical study with this compound.

SUMMARY

1. The study of a drug with potent pharmacological properties in the animal, was undertaken clinically in reactive depression (depression seemingly based on other organic disease in 305 patients).

2. Results, after serious consideration of the limitations and difficulties in studying drugs in somatopsychic disorders, encourage us to recommend this compound for further study.

In our hands, chlordiazepoxide proved to be a valuable adjunct in the management of the type of depression reported.

Librium, brand of chlordiazepoxide, provided for this study by Dr. M. J. Schiffrin of Hoffmann-La Roche Inc.

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TAPE RECORDINGS OF THE OCTOBER, 1960 MEETING

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|---|--|
| 1 Emotional Aspects of Allergy and Dermatology
Handling the Patient with Chronic Illness | 2 Interview Techniques
Psychiatric Education for the Non-psychiatrist |
| 3 Sterility and Frigidity
Emotional Problems in Surgery and the Surgical Specialties | 4 Psychopharmacology I
Psychopharmacology II |
| 5 Psychosomatic Medicine Round Table | 6 Group Therapy
Chest Pain—Somatic and Psychic Factors |
| 7 Are Drug Therapy and Psychotherapy Compatible?
The Doctor as a Therapeutic Agent | |

Through the efforts of Dr. Milton Cohen of Lewiston, Pa., we now have tape recordings available of some of the sessions held at the October 1960 meeting in Philadelphia. The tapes listed above may be purchased for \$9.50 each. Please make checks payable to the Academy of Psychosomatic Medicine and send with order to the editor, at 1921 Newkirk Avenue, Brooklyn 26, N. Y.

Pitfalls and Problems in Clinical Psychopharmacology

DOUGLAS GOLDMAN, M.D.

Clinical medicine, which includes clinical psychopharmacology, persists as an art and as such requires aptitude, talent and experience as well as pure knowledge. This art may be likened to the art of painting. One may supply a prospective artist with the best tubes of pigment suspended in oil or to be dissolved in water, the very best camel's hair and sable brushes, the most perfectly structured and textured paper and canvas, and the most beautifully-grained mahogany palette, and yet the result of his effort can be recognized only as a meaningless smear if he lacks ability, or as a true work of art appreciated by his professional confreres as well as the world in general, if he has aptitude, talent and experience. The wonderful array of chemical substances we now have available for treatment of emotional and mental illness may be considered analogous to the array of colors available to the painter, and the illness itself to the canvas or paper upon which the creation is to take place. I shall try to indicate by report of specific experience some of the ways in which clinical creativeness can be obstructed and distorted and some ways in which it can be advanced and made more secure.

Clinical problem situations can originate in a number of ways. These have to do with 1) proper psychiatric diagnosis and choice of patients; 2) problems created by improper administration of drug or drugs, originating (a) with the patient, and (b) with the physician; 3) management of side-effects from medication.

It is important to recognize that many patients who have what are obviously emotional difficulties do not require medication or shock treatment for their relief.

Simple help in achieving an understanding of the nature of the problem and carrying out necessary environmental manipulation is of much more importance than medication in such instances. An example is the patient with an obvious emotional upset who practically demanded medicine for relief, since she had previously been relieved by medication for an emotional illness. However, a patient's demand for medication has never been considered a sufficient indication for it. By application of firmness and guile, the patient brought out the fact that she had suddenly discovered inadvertently, after 15 years of marriage, a middle-aged marriage of comfort and convenience, that her husband had been married at the time of the first World War. As a good Catholic she considered herself finished and consigned to her doom since she was involved in marriage to a man with a living former spouse, regardless of legal divorce and 40 years of time. The remedy in this situation was obviously in the canon law rather than in a box of pills, as subsequent consultation with the clergy adequately proved.

It is necessary to be alert and attentive even with patients long known to the physician as chronic neurotic, depressive, hypochondriacal individuals. Such people are susceptible to infections and other organic diseases to the same degree as are other human beings. Two specific instances are called to mind. One was a patient known for many years who periodically under environmental stress developed pains, discomfort, tremulousness and other symptoms. These frequently had been relieved by medication. The persistent pain in the chest, substernal and left-sided, however, was associated with a moderate fever of 101° F. Roentgenographic examination showed characteristic find-

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ings of probable left lower lobe pneumonia and associated pericarditis. Obviously no amount of anti-depressant medication or phenothiazine would benefit such a condition. However, several weeks of adequate treatment with antibiotics relieved this condition entirely and re-established what might be considered the "normal" status, requiring a small amount of antidepressant medication which made it possible for the patient to return to work.

Another was a patient who was long known as a depressive individual and who was resentful of herself and the world. Complaints of weakness and faintness and call of a sister brought me to her. The patient was found practically exsanguinated and vomiting blood. Hospitalization, multiple transfusions and eventually gastrectomy for a chronic, bleeding, perforating ulcer, led to recovery from the physical illness and re-establishment of the status quo ante, for which supportive psychotherapy and antidepressant medication were appropriate. This patient has also returned to work.

Such patients are similar to the shepherd boy in the children's fable, who for the purpose of getting attention and company, shouted "wolf." Clinical alertness is necessary to distinguish the true nature of the distress signal. This requires the physician to achieve intimacy with clinical illness on an individual basis. It is not possible in the management of large groups of individuals who represent only statistical fractions.

Medication appropriate to the patient's diagnosis is essential for a favorable result in any kind of treatment. It is inappropriate to treat a depressed patient with any of the commonly available phenothiazines or meprobamate. An example is the woman of involutional years who had become tearful, withdrawn, inert and a burden to herself and her husband. Her family physician had prescribed chlorpromazine and, in the absence of benefit after some weeks, meprobamate. Con-

tinued illness made consultative special care necessary. The withdrawal of chlorpromazine and meprobamate and the application of imipramine in adequate doses, helped the patient return to an extroverted, happy, pre-morbid way of life in relatively few weeks.

In similar fashion, it is inappropriate to treat patients with schizophrenic reactions with antidepressive medication. To prove that I am as human as anyone, I can cite instances from my own practice in which schizophrenic patients who seemed to have been relieved from paranoid and hallucinatory experience and functioning, but who continued to be relatively inert, were treated with antidepressant medication. In every instance the antidepressant medication, whether hydrazide or Imipramine within a few weeks produced recurrence of paranoid antagonistic functioning which required withdrawal of the antidepressant medication and for a time an increase in the dose of useful phenothiazine.

In psychiatry, as in other branches of medicine, it remains necessary for medication to fit the illness. The examples above are, therefore, illustrative of individuals 1) who require no medication, 2) for whom appropriate medical rather than psychopharmacologic treatment is required, and 3) for whom the pharmacologic treatment should be appropriate for the illness that is manifest.

Proper and adequate dosage of the drug being administered is an important principle of therapeutics. In the state hospital and in private practice, it is equally important to be sure that the patient is actually taking the medication prescribed. With the help of the newer tests for excretion of phenothiazines, this is somewhat more readily determined, although laboriously at times. We have a collection of jars of tablets returned to the state hospital by social workers when patients seemed to relapse under medication. It is obvious since the patients collected the

medication in jars rather than in their own metabolic apparatus, that the failure was not of the medication. The principle to which we therefore adhere is that if a patient shows no apparent effect of the medication, we believe he is probably not taking it. This point of view has long been the policy in sophisticated psychopharmacologic circles.

The counterpart of inadequate medication resulting from patient failure to participate in the treatment program is the over-enthusiasm of the patient for the treatment, which may lead to his taking excessive amounts of a drug. This calls to mind the individual patient who, because she had forgotten a few pills for a few days, decided to take three days' supply of medication in one day. This led to a call from a probate court social worker from an adjacent county. The patient had been picked up in a confused and somnolent state related to the ingestion of approximately 2400 mg. of chlorpromazine rather than her usual 800 mg. per day, which she had tolerated over an extended period with marked benefit.

Such enthusiasm for treatment, particularly in depressed individuals who are taking hydrazides, can lead to precarious situations from hypotensive reactions. Orthostatic hypotension from intake of the hydrazide antidepressants is a well recognized effect. It is important to indoctrinate patients adequately with respect for the drugs they are taking so they may avoid the unfavorable effects of their own ignorance. Needless to say, patients who suffer the effects of orthostatic hypotension develop unfavorable emotional reactions to the treatment which require adequate interpretation. They require also proper adjustment of the medication and treatment of the side effect.

Another problem of medication that exists in the state hospital as well as in private practice is the problem of what might be called "non-medical" competition. This

is illustrated by a story derived from Dr. George Brooks of Vermont. A patient was asked how he slept the night before. He replied, "I slept fine in spite of taking that new medicine of yours. I borrowed one of Joe's Thorazine pills last night." How much such incidents have influenced the results of double blind experiments in the last few years is difficult to estimate. In private practice there are similar problems resulting from trading of medication over the bridge table, at cocktail parties and elsewhere, as many of us sadly realize. It is particularly important to keep such possibilities in mind in attempting to evaluate and understand unusual effects of medication and unexpected side effects.

At this point a particular problem of social, pharmacologic importance must be considered. We must set aside all personal preference and bias in this connection. I am referring to the unfavorable effect of alcohol in all emotional and mental illness. In our state hospital experience, relapse in spite of continued adequate medication has been almost invariably associated with intake of quantities of alcohol which would by ordinary standards be considered socially normal and acceptable. I am not referring to alcoholic psychoses at all, but to the adverse effect of alcohol in depressive and schizophrenic illness as well as severe psychoneurotic manifestations. It is a problem to be contended with not only in private and out-patient practice, but also within the limits of the state hospital itself.

Some failures in pharmacologic therapy of mental illness are the result of inadequate dosage. A simple and brief example can be cited here. J. was a schizophrenic patient who had been through the vicissitudes of long-term treatment with insulin, electroshock and finally a lobotomy prior to the advent of the newer drugs. When chlorpromazine first came into use, she naturally was given the benefit of the drug. She continued to live in her dream world, mis-identified people she had long

known, and took no interest in any of her former activity or in her family, even when she was receiving 900 mg. per day of chlorpromazine. When the dose was increased to 1200 mg. per day, 400 mg. t.i.d., she emerged from her cocoon; she identified the physician that she had recognized in intermittent lucid periods in the past. She resumed her interest in commercial art and resumed her normal affectionate relationship with her son and husband. This has continued uninterrupted for a number of years now so that the recovery can be said to be adequate. It is evident that with a smaller dose than that necessary to relieve the symptoms, she might have been considered resistant to treatment and consigned to the limbo of the "back ward."

Side effects from the use of psychopharmacologic agents probably are the largest source of anxiety to the practitioner, whether in a special field or in general medicine. These have had a great deal of unfavorable publicity, and a certain amount of adequate sensible discussion, but it is still hardly possible to say that adequate knowledge is general. No attempt will be made to describe all of the side effects of psychopharmacologic agents since this would require a long monographic paper. A few important problems, however, will be mentioned.

The depressant effect of the phenothiazines and reserpine and, what is frequently not recognized, of meprobamate, must be promptly detected to avoid tragedy. A single instance will suffice to indicate the nature of the problem. A late middle-aged woman with no previous psychiatric disorder had been treated for bursitis with a combination of Prednisone and acetylsalicylic acid with moderate success. When a similar combination with the addition of meprobamate was introduced, the muscle relaxing effect of the meprobamate was thought to be an ideal addition for this patient, so it was substituted for the simpler medication. Within two days, the

patient appeared at the office in tearful condition with obvious dysphoric depressiveness, indicating that it was her desire to go to the river to join her deceased husband and son. Withdrawal of the medication produced relief within two days. Similar problems in other patients treated with meprobamate have been seen and will be incorporated into a report at some future time. The depressive effects of reserpine and chlorpromazine and of other phenothiazines, have been reported adequately and require no special documentation.

The problem of dramatic neurologic effects is a multiple one. Promazine, widely acclaimed as beneficial for acute alcoholism, has also been recognized as productive of convulsive manifestations, particularly at higher dose levels. The convulsant effect sometimes is synergistic with the withdrawal effect in chronic alcoholism which also can produce convulsive manifestations. It is wise to keep this in mind, and to limit the use of Promazine to a few doses in the most acute part of the situation, or to use one of the less convulsant phenothiazines which can produce equal benefit in alcoholism.

That some of the more active phenothiazines can produce acute neurologic disturbances such as dystonic reactions, particularly trismus, torticollis, oculogyric crises and sometimes more generalized dystonia, has long been recognized. These effects must be differentiated from actual neurologic illness such as encephalitis, brain tumor, etc., since the drug reactions are readily relieved by various kinds of medication, as through the intravenous use of good anti-Parkinson agents as well as some of the antihistamines which have associated anti-Parkinson effect. This tendency to produce the neurologic manifestations of parkinsonism may at times produce confusing situations in private practice where physicians are not sufficiently aware of these manifestations.

A final instance will be cited. A woman

in her early 40's who had complained of manifestations of the menopause and "nervousness" had received some estrogenic hormone from an obstetrician. When she did not respond adequately, he gave her some capsules to relieve the nervousness. These were Compazine spansules. When they did not work adequately, she was told to take the medication twice daily. When twice daily was insufficient to produce relief, she was given in addition some blue tablets, obviously Stelazine, which also did not relieve the situation that had developed. When she was observed walking into the office, the immediate impression was that a now unusual neurologic illness was presenting itself, possibly one that had not been seen for a number of years, neurosyphilis. When the aforementioned history, however, was related, it was immediately evident that the problem was considerably simpler. The patient was instructed to discontinue the medication she had. She was given a three days' supply of Akineton, an anti-Parkinson drug introduced about a year ago; when she was seen again in three days, she had recovered

from all of the manifestations of her difficulty. She was smiling and happy, had no nervousness and has been able to get along well since.

This discussion would hardly be complete without an appeal for moderation in the use of psychopharmacologic agents. This is best illustrated by examples of multiple medication to which patients have been subjected all too frequently. Illustrated are instances of five and of eight different drugs to which patients have been exposed. After reasonable psychotherapeutic approach and resolution of the social and family problems which produced the difficulties in these patients, no medication was actually necessary at all.

In closing we can refer again to the opening theme that life is short and that art is long and that this is true nowhere more clearly than in the clinical application of pharmacologic agents. We can recall the caustic answer given by a great American artist whose sharpness of tongue was proverbial: Whistler, when asked with what he used to mix his paints replied tersely, "Brains." As Alexander Wolcott used to say, "The defense rests."

It may be difficult to suppress the hope . . . that some future Sydenham will discover an anti-psychosis which will as safely and speedily cut short an attack of mania or melancholia as bark an attack of ague.

Daniel Hack Tuke

(Quoted by Gregory Zilboorg, M.D., *A History of Medical Psychology*, W. W. Norton & Co., p. 431.)

A Note on Psychosomatic Medicine

H. KEITH FISCHER, M.D.

Psychosomatic medicine is a term implying the effective integration of good psychiatry and good medicine. It evolves from the classical organic, physiologic and pathologic concepts of disease, but special problems occur when the increasing body of knowledge of modern dynamic psychiatry is added. Scientific psychiatry has developed parallel to unscientific individuals and groups through the areas of witchcraft, demonology, magicians, soothsayers, ecclesiastical authorities, the charlatans, the Mary Baker Eddy's, the bartenders, the individuals with the "placebo personalities" and the "glib-talking spellbinders." The latter have their successes too. The basic problem has been to determine the standards and controls to keep this at a constructive and therapeutic level. This problem is unique. It will be resolved by the integrity of the individual physician plus taking out the magic and replacing it with scientific knowledge. The emotion and personality of the physician enters this far more than in other areas of medicine where rational intellect and manual dexterity are usually sufficient. This problem is difficult and will be an everlasting one. In this regard I must propose several general principles.

First, that the basic science is the human individual with his tissue pathology and his psychopathology. All begins here and all returns to here. Thus psychiatry must be based at a medical biological level.

Secondly, the basic integrative principles would have to apply and have appropriate meaning to both physiology and psychology. Let me mention a few. First, Cannon's principle of homeostasis—the tendency for both the psyche and the phys-

iology seek a steady state. The steady state may be at a level which is destructive to the organism, or destructive to society, or it may be at a healthy or constructive level. Therefore, Fechner's principle, number two on my list, calls attention to the tendency of the organism to keep tensions at the lowest level. This means that psychologically and physiologically, homeostatic levels which are destructive become the focus of a variety of efforts to replace them with more healthy and comfortable levels. If this is accomplished, my third basic principle would involve Alexander's theories concerning the priorities of energy investment. The basic priority is existence. If this is adequately taken care of the excess energy goes to creativity and if this in turn is satisfied, any left over energy would go into play. The definition of "play" would be anything done simply for the pleasure of it. The tools for making these clinical and therapeutic involves knowledge of the unconscious, as defined by Freud, as the conditioning center in which sensitivities from the past childhood experiences, the outside environment and the present come together with the activity of the ego to handle it.

If these principles are basic pillars which can be accepted as applying both to the body psychology and the body physiology, the applications, both in understanding disease and planning therapy, can be put on an acceptable and rational basis and the integration becomes operationally, theoretically and rationally sound. In doing this the re-emphasis on clinical research and the re-writing of a physiology with the intact mind is an important goal. When the growth and maturity of the physician accompanies the success of this effort medicine will be closer to its greatest contribution in prevention of disease and suffering.

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Pruritus: A Symptom of Depression

SAMUEL I. GREENBERG, M.D.

It is well-known that depression may manifest itself by a great variety of somatic symptoms and may simulate functional or organic disease.¹ It is not so well-known that pruritus may be a manifestation of depression, and will often resist all attempts at treatment until the underlying depression is treated. In my experience, this occurs much more commonly than is generally recognized. The pruritus may occur without any objective evidence of cutaneous disturbance, so-called idiopathic pruritus, or it may appear as an exacerbation of the itch that regularly accompanies many dermatologic conditions.

Quite a few observers have noted depression in patients with chronic, pruritic dermatoses who failed to respond to treatment until the depression was treated. MacCormac and co-workers² found that depression and anxiety occur in such patients, "either as a prelude or sequel to the skin disease." Treatment by the continuous narcosis method of Sargent and Slater gave good results in most of their series of 17 patients. Carslaw³ felt that amphetamine was sometimes of value in those patients who "became depressed and lose the will to recover." Wright⁴ reported the case of a middle-aged physician with generalized pruritus who proved refractory to all treatment, until a psychiatric consultant made the diagnosis of a "breakdown" and recommended electroshock treatment. Following this, he made a dramatic recovery and remained well for many years. Craddock and Krebs,⁵ and Andrews⁶ have also reported on the use of electroshock treatment in dermatologic patients. Macalpine⁷ found depressive

trends to be common in 64 patients with pruritus ani, and at times obtained good results with relatively brief psychotherapy. Guy and Shoemaker⁸ found that in atopic eczema a "constant accompaniment of exacerbation, is depression" and cautioned that this should not be taken lightly; there were two suicides in their series of 61 patients. They found group therapy to be as helpful as individual psychotherapy. Rothenberg⁹ has reported on the co-existence of depression and psychosomatic disorders; one patient with pruritus ani and another with angioneurotic edema were relieved of their symptoms by psychoanalysis.

This subject is especially timely now with the development of the psychic energizing drugs. With them, and the tranquilizers, the general practitioner and non-psychiatric specialist have effective adjuncts for the treatment of depression.

REPORTS OF CASES

Case 1: A 45-year-old man with exudative, discoid and lichenoid dermatosis (Sulzberger-Garbe) was referred to me on January 4, 1954 by a prominent dermatologist. The illness began eight years ago and at first had been intermittent and relatively mild. In the past five months it became progressively more severe, and involved the entire trunk and all extremities. All local and systemic medication had been ineffective; during a period of hospitalization he became worse. Cortisone was then available, but not given because of a duodenal ulcer. In the week preceding his visit to me, he scratched continuously, ate little, and could only sleep for very short intervals. He repeatedly told his family that he couldn't live this way and threatened suicide. The initial interview revealed the characteristic picture of a severe agitated depression. Electro-convulsive therapy was recommended, and he received seven treatments between January 16 and February 1, 1954. After the fourth treatment, the pruritus stopped; after the seventh treatment the depression had almost entirely lifted and the skin was very much better. He remained well for seven months, and then suffered a milder recurrence of depression

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and the dermatosis. After discussing it with me, he decided that the best solution of his family problems would be to move away from New York City and his in-laws. He moved to El Paso, Texas, and four months later he wrote to inform me that the depression was gone and that his skin was almost back to normal.

Case 2: A 60-year-old factory worker was referred to me on April 2, 1955 with a Sulzberger-Garbe dermatosis of one year's duration. Three dermatologists had treated him with x-ray, Grenz ray, cortisone and a great variety of topical medication. A two-week period of hospitalization resulted in some improvement, but his return home was followed promptly by a relapse. He lost interest in his usual activities, stopped going to work, couldn't sleep, lost weight and scratched continuously. During the interview, his expression was one of great sadness and resignation. He spoke very little in a slow, barely audible voice. The patient was referred for electroconvulsive treatment, and improved dramatically after five treatments. In six weeks the depression lifted, the dermatosis was greatly improved, and the patient returned to work.

Case 3: A 54-year-old widow was referred to me on September 12, 1957 by a dermatologist for a generalized neurodermatitis of seven months duration, after all his attempts at treatment had been ineffective. She didn't sleep well and had lost 26 pounds during this time. The itching was severe. During the interview the patient at first gave the impression of a confident and poised person, quite capable of dealing with her problems. However, as the history unfolded, it was evident that this was only a facade. She had had an unhappy marriage; her only child had died; and she had recently been forced to liquidate her small business. Later, she admitted worrying a great deal about her ability to support herself. She lived alone and was often lonely and depressed. The Rorschach test findings were consistent with depression. The patient was placed on iproniazid (Marsilid, Roche), and came for psychotherapy. Within five weeks there was great improvement.

Case 4: A 50-year-old woman first consulted me on September 23, 1959 for severe itching of the arms and forearms of several weeks' duration, and a recurrent pruritus ani of nine months' duration. Eight years before her 15-year-old daughter had died, and since then she has had recurrent episodes of severe depression with crying spells, insomnia and inability to work. She had been under a psychiatrist's care from November 1958 to January 1959 and received tranquilizers. On August 31, 1959 she visited her daughter's grave on the anniversary of her death, and for the first time had not cried or

been too upset. However, that night she awoke from sleep with a severe itching of the arms and forearms. When she scratched in the office, her movements were reminiscent of a mourner at a funeral tearing at her clothes. The patient's agitation became much worse in spite of drugs; her speech became rambling and disconnected. The psychiatric diagnosis was: depressive phase of manic-depressive illness, and she was referred for electroconvulsive therapy.

Case 5: A 60-year-old married woman was referred to me on August, 1960 by a gynecologist for an anogenital pruritus of three years' duration. She had been thoroughly worked up and all systemic or local causes of the pruritus had been ruled out. The patient cried a great deal in the course of taking a history, and readily talked about her vexing family problems. She was placed on Tofranil (Geigy) 25 mgm. T.I.D., and in two weeks was very much improved.

COMMENT

From my experience, and from the literature, I am led to believe that pruritus is a more common manifestation of depression than is generally recognized. From the viewpoint of psychodynamic theory, it is not surprising to find this relationship. Many observers have felt that excessive itching and scratching are self-punitive: or to state it another way: hostility is turned against the person himself. This is the very same dynamic mechanism we find in depression. As with other symptoms due to emotional conflict, itching and scratching have a defensive value in maintaining the psychic balance. Too rapid removal of symptoms, as by hypnotic suggestion, may be followed by a frank psychosis. Such cases have been reported. It is also interesting to note that most of these patients are middle-aged and elderly, the very age groups in which depression is more frequent.

The depression in these patients may be classified, psychiatrically, as neurotic (case 5), borderline (case 3), and psychotic (cases 1, 2 and 4). In this last group, patients with psychotic depressions masquerade as difficult dermatologic problems, and are often inadequately treated. The correct diagnosis is ordinarily not difficult to establish if a thorough history

is obtained, and the patient observed for evidence of psychomotor retardation or agitation.

SUMMARY

Severe and persistent pruritus may, at times, be a manifestation of depression, and will often prove refractory to treatment until the underlying depression is adequately treated. It is suggested that this occurs more frequently than is generally recognized. Five illustrative case histories are reported.

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ON LIFE

A platitude has come home to me with quasi-religious force. I was repining at the thought of my slow progress—how few new ideas I had or picked up—when it occurred to me to think of the total life and how the greater part was wholly absorbed in living and continuing life—victuals—procreation—rest and eternal terror. And I bid myself accept the common lot; an adequate vitality would say daily: "God—what a good sleep I've had." "My eye, that was a dinner." "Now for a rattling walk—" in short, realize life as an end in itself. Functioning is all there is—only our keenest pleasure is in what we call the higher sort. I wonder if cosmically an idea is any more important than the bowels.

Oliver Wendell Holmes—Quoted in N. Y. Times Magazine, March 5, 1961.

Clinical Investigation of Acetophenazine (Tindal) a New Phenothiazine

MARSHALL E. SMITH, M.D.

New and supposedly "better" tranquilizing agents, that is, compounds with supposedly greater efficiency and lower side-effect potential, are being submitted for clinical investigation almost daily. Recently, a new phenothiazine derivative, acetophenazine, was selected for clinical trial on the basis of observations in laboratory animals, which indicated that this agent is capable of suppressing conditioned avoidance behavior and is relatively non-toxic. In addition, the response to the tremorin test suggested that acetophenazine may be devoid of significant extrapyramidal effects.¹ This laboratory finding was considered most interesting, since heretofore some workers have suggested that there may be a ratio between the activity of a phenothiazine derivative and the incidence and degree of extrapyramidal effects it causes.^{2,3}

This investigation was carried out as a three-part study. The first part consisted of a pilot study primarily conducted to determine the clinical toxicity of acetophenazine as well as to establish its optimal dosage range; the second part was a blind study comparing acetophenazine with chlorpromazine and a placebo in hospitalized psychotic patients, and the third part consisted of a clinical evaluation of acetophenazine in a series of out-patients with psychoneurotic disorders.

CHEMISTRY

Acetophenazine is a member of the piperazine group of phenothiazines (shown in fig. 1), which also includes fluphenazine, prochlorperazine, perphenazine, thiorpropazine, trifluoperazine, and acetophenazine.

zine, prochlorperazine, perphenazine, thiorpropazine and trifluoperazine. These derivatives all have a piperazine ring in the side chain and, of the phenothiazines in current use, appear to have the highest milligram activity and the lowest side-effect potential.⁴

Acetophenazine is 1-(2-hydroxyethyl)-4-[3-(2-acetyl-10-phenothiazinyl) - propyl]-piperazine dimaleate.

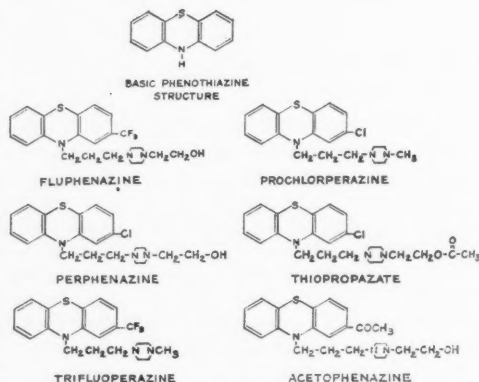


Figure 1.

PART I—PILOT STUDY

Patient Material

Twenty-four hospitalized psychotic patients, all females, ranging in age from 22 to 59 years, were selected for this study. The length of hospitalization of these patients ranged from two to 28 years, with an average of 12.5 years. A deliberate effort was made to select the less responsive cases: the majority of these patients had previously been subjected to various types of psychiatric activity and treatment ranging from a "total push program" to electroshock, and were considered treatment failures by the psychiatric staff.

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Formerly Director of Research, Connecticut State Hospital, Middletown, Conn., where part of this study was carried out.

Methods

All therapy was withheld for one month prior to institution of treatment with acetophenazine, and it was the staff's impression that there was no carry-over from previous treatments. The majority of patients had not received any therapy for six months, since they had been considered treatment failures. Blood studies (CBC), liver function tests (Van den Bergh, icteric index, cephalin flocculation and urine urobilinogen) and urinalyses were carried out in all patients prior to the institution, and at regular intervals during treatment with acetophenazine.

The results obtained in animal studies had suggested a dose of 5-10 mg. t.i.d. However, as is the case more often than not, this did not prove to be the optimal dosage in human subjects and only mild evidence of tranquilization was seen at this level. Thus, dosage was gradually increased until it had reached 240-400 mg. daily, given in divided doses, in most cases; only four patients received a lower daily dosage. The duration of treatment varied from two to ten months. Group therapy, individual therapy and routine ward activity were continued, as usual, during this study.

All patients were evaluated weekly by physicians and nursing personnel involved in the study. Using a standard rating scale, patients were rated in the following manner: +3 if there was marked change in behavior and psychosis; +2 if change in behavior and psychosis was moderate; and +1 if there was a mild change in behavior. Patients were rated 0 if there was no change; -1 if they showed a mild degree of behavioral deterioration; -2 if both behavior and psychosis became moderately worse; and -3 if both became markedly worse.

Results

Using the criteria outlined, final evaluation revealed that one patient experienced marked improvement and 14 mild

to moderate improvement, while five showed no change and four experienced a mild degree of behavioral deterioration. Table I shows a breakdown of these results.

TABLE I

Results with Acetophenazine in 24 Hospitalized Psychotic Females

Age range: 22-59 yrs.; average hospitalization: 12.5 yrs.

	No. Cases	Rating						
		+3	+2	+1	0	-1	-2	-3
Chron. paranoid schizophrenia	15	-	5	4	4	2	-	-
Chron. hebephren. schizophrenia	2	-	1	-	-	1	-	-
Chronic undif. schizophrenia	7	1	-	4	1	1	-	-

- +3 marked improvement in behavior and psychosis.
- +2 moderate improvement in behavior and psychosis.
- +1 mild improvement in behavior and psychosis.
- 0 no change.
- 1 mild deterioration in behavior.
- 2 moderate change in behavior and psychosis.
- 3 marked change in behavior and psychosis.

With the exception of one case of temporary, mild hypotension accompanied by dizziness, no side effects were observed. It is noteworthy that there were no extrapyramidal reactions in spite of the relative efficacy of acetophenazine in this group of patients.

PART II—BLIND STUDY

Patient Material

Forty-five hospitalized psychotic male patients, ranging in age from 27 to 65 years, were selected for this study. The length of their hospitalization varied from two to 37 years. These patients were divided into three groups, each receiving one of three medications—acetophenazine, chlorpromazine or placebo. The majority of these patients had received various forms of treatment prior to inclusion in this study.

Methods

Three medications of identical appearance were used; one contained 50 mg. of acetophenazine in each capsule, one 50 mg. of chlorpromazine, and one inactive material.

The members of the staff and the patients did not know which capsule contained which medication. Sixteen patients were given acetophenazine, sixteen chlorpromazine, and sixteen the placebo. Patients were started on two capsules a day and gradually increased to 12 capsules daily, and then decreased to three to six capsules per day. Thus, those receiving acetophenazine or chlorpromazine were given maximum daily doses of 600 mg. Duration of therapy was four months in all patients.

The same laboratory procedures and rating methods used in the pilot study were employed in these patients.

Results

As shown in Table II, of the 16 subjects receiving acetophenazine, 11 experienced mild to moderate improvement, while five remained unchanged. Six patients suffered from lethargy, while a mild extrapyramidal reaction was seen in one. All laboratory tests proved negative.

TABLE II

Results with Acetophenazine in 16 Hospitalized Psychotic Males

Age range: 27-64 yrs.; average hospitalization: 12 yrs.

	No. Cases	Rating			
		+3	+2	+1	0
Chron. paranoid schiz.	7		3	3	1
Chron. hebephrenic schiz.	3		1	1	1
Chron. undif. schiz.	1		-	-	1
Chron. catatonic schiz.	3		1	-	2
Simple schiz.	2		2	-	-

As shown in Table III, of the 16 patients receiving chlorpromazine, two experienced marked improvement, seven

mild to moderate improvement, and seven remained unchanged. The only side effect observed was one case of lethargy. All laboratory values remained within normal ranges.

TABLE III

Results with Chlorpromazine in 16 Hospitalized Psychotic Males

Age range: 28-70 yrs.; average hospitalization: 15.5 yrs.

	No. Cases	Rating			
		+3	+2	+1	0
Chron. paranoid schiz.	5	1	1	1	2
Chron. hebephrenic schiz.	3	1	1	-	1
Chron. undif. schiz.	4	-	2	-	2
Chron. catatonic schiz.	1	-	-	-	1
Simple schiz.	1	-	1	-	-
Chronic brain syndrome with psychotic reaction	2	-	-	1	1

Table IV shows that only two of the 16 patients receiving placebo experienced mild improvement, while 11 remained unchanged; the other three were moved and thus lost from this study. There were no side effects, and laboratory values remained within normal ranges.

TABLE IV

Results with Placebo in 16 Hospitalized Psychotic Males

Age range: 33-65 yrs.; average hospitalization: 13 yrs.

	No. Cases	Rating			
		+3	+2	+1	0
Chron. paranoid schiz.	4	-	-	-	4
Chron. hebephrenic schiz.	5	-	-	2	3
Chron. undif. schiz.	2	-	-	-	2
Chron. catatonic schiz.	2	-	-	-	2

NOTE: Three patients were lost from the study.

PART III—OUT-PATIENT STUDY

Patient Material

This study comprised 23 patients suffering from psychoneurotic disorders, chosen at random from the author's private prac-

tice. There were 15 females and eight males, ranging in age from 17 to 53 years. Of these 23 patients, nine had acute anxiety reactions, one a phobic reaction, seven psychoneurotic reactions of mixed type, and six showed anxiety reactions associated with somatic illnesses. This last group of six cases included three with duodenal ulcer, one with functional diarrhea and two with vague, undefined gastrointestinal distress accompanied by overwhelming anxiety and cancerphobia.

Methods

Dosage varied from 20 to 40 mg. daily, in divided doses. Patients were evaluated by the author at appropriate intervals. In view of the safety shown by acetophenazine in both the pilot study and the blind study, it was felt that laboratory tests were not required with the low dosages employed in these patients.

Results

Table V shows that of the nine patients with acute anxiety reaction, five showed marked improvement, while the medication was discontinued after two weeks in four when no improvement was obtained; of the seven cases of psychoneurotic reaction of mixed type, four showed moderate improvement, one slight improvement, and two remained unchanged; of the six patients with anxiety associated with somatic illnesses, three showed marked improvement, one slight improvement, and two remained unchanged. The patient with the phobic reaction failed to show measurable improvement, although in this case the dosage had been gradually raised to 300 mg. daily.

DISCUSSION

This three-part study indicates that acetophenazine is a phenothiazine derivative with an exceptionally low order of toxicity and minimal side-effect potential. This agent appears to be very effective in psychoses, as may be seen from the results, showing some degree of improvement in

TABLE V

Results with Acetophenazine in 23 Psychoneurotics

15 females, 8 males; age range: 17-53 yrs.

—Improvement—

	No. Cases	Marked	Moderate	Mild	Unchanged
Acute anxiety reaction	9	5	1	1	4
Psychoneurotic reaction, mixed type	7	—	4	1	2
Anxiety with somatic illness	6	3	—	1	2
Phobic reaction	1	—	—	—	1
		8	4	2	9
Total improved		14			

39 of 48 psychotic patients comprising the pilot and blind studies. These figures are rather encouraging when one considers that these were all hospitalized chronic psychotics, the majority of whom had failed on one or more previous therapies. Acetophenazine also may prove useful in the management of certain types of psychoneuroses, as may be seen by the improvement obtained in 14 of 23 such cases.

It is interesting to note that while acetophenazine belongs to the piperazine group, it is capable of producing some degree of sedation, a characteristic generally associated with the so-called chlorpromazine model group of phenothiazines.

The principal usefulness of acetophenazine appears to be its capability of eliciting improvement in chronic psychotics, including those who have failed to respond to other therapies, without inducing significant extrapyramidal reactions or other undesirable effects of a serious nature.

Thus, acetophenazine is a useful addition to the psychotherapeutic agents currently available.

SUMMARY

1. A three-part study of a new phenothiazine derivative, acetophenazine, was carried out to determine its usefulness in

the management of psychotic and psychoneurotic patients as well as its order of toxicity.

2. Acetophenazine proved an effective tranquilizing agent in hospitalized chronic psychotics and a useful compound in certain types of psychoneuroses.

3. The only side effects seen in this study were seven cases of lethargy, and one case of temporary, mild hypotension. Thus, acetophenazine exhibited an exceptionally low order of toxicity and a minimal side-effect potential. The absence of significant extrapyramidal reactions

should be considered an important feature in the usefulness of this agent.

124 Whitfield St., Guilford, Conn.

The acetophenazine used in this study was kindly furnished by J. Black, M.D., and Edward McMahon, M.D., Division of Medical Research, Schering Corp., Bloomfield, N. J.

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In the field of mental health, the use of psychotropic drugs made possible savings of an estimated 860 million dollars in state mental hospital construction costs in a single three-year period by reducing the length of hospitalization required for thousands of patients.

National Committee Against Mental Illness, Inc.
What Are the Facts About Mental Illness?

(Quoted by Austin Smith, M.D., The Pharmaceutical Industry Reports, J.A.M.A. for Aug. 13, 1960, Vol. 173, No. 15, p. 1654.)

The Group Treatment of the Chronic Somatic Complainer

J. KENNETH McDONALD, M.D., and BETTY SUE GANDY, M.S.W.

Physicians often refer to chronic, somatic complainers by generally uncomplimentary terms. These terms are generally used as an expression of hostility towards these patients. This hostility is the result of frustration generated by the patients' infinite somatic complaints put in such a way that they demand something be given or done for them. These patients may have a variety of psychological and organic pathology and diagnoses but they have in common their continuing complaints. They are among the most difficult of patients to manage, whether treated primarily by the general practitioner, internist or psychiatrist. Their treatment usually terminates only with their demise. They constitute not only a constant problem to those involved in their treatment but also a continuing economic burden to the community.

Although they are by no means unfamiliar to the private practitioner, they are primarily found in indigent out-patient clinics. They are certainly readily available at the University Clinic of the Medical College of Georgia, where they are usually referred for psychiatric evaluation and treatment at some time in their clinic careers. This paper reports on a group treatment that attempted to provide a better and more economical approach to the management of six of these patients. The primary purpose of the group approach was to focus on the psychological aspects of their chronic complaints. To some extent, however, the patients' actual somatic pathology and economic difficulties were attended to in the group setting.

METHODS

Form letter invitations to attend the group were sent to all white females fitting the criteria mentioned above who were attending the psychiatric clinic at the time. Ten letters were sent out and nine patients responded. During the first few meetings three of the patients dropped out, leaving six members who continued. The group met at a regularly scheduled psychiatric clinic time in one of the clinic rooms. A few extra chairs were placed in the room and the examining table was moved into one corner. The setting was otherwise typical for an examining room in an indigent clinic: hot, small, pediatric clinic in progress next door, and a railroad yard within twenty-five yards of the window.

The meeting was divided into two sections. The first 45 minutes were devoted entirely to psychological aspects of the patients' "illness." There were two therapists, the authors. The remaining 15 minutes were then spent attending to actual minor physical pathology. Consults with other clinics were obtained as indicated. During this time attempts were also made to evaluate and, where indicated, to provide help for economic problems that arose. The clinic met once each week for eight months and every other week for the next two months. This report covers the ten month period. The clinic was to continue on an every other week basis thereafter.

DESCRIPTION OF THE GROUP

Some of the information describing the group members can be noted in Table I.

There were several rather marked similarities in the patients' past histories. All but one had been raised in a rural setting,

From Department of Psychiatry and Neurology of the Medical College of Georgia.

TABLE I
Factual Data Concerning Patients in the Group

Patient	Age	Monthly Income	No. Living on Income	Current Medical Diagnoses	Current Psychiatric Diagnoses
Miss E.	55	\$53	3	Osteoporosis Osteoarthritis Acromioclavicular Syndrome	Mental Deficiency Schizoid Personality
Mrs. R.	58	\$139	3	Obesity Myomata of Uterus	Conversion Reaction Passive Aggressive Personality
Mrs. J.	56	\$65	2	Osteoarthritis Chronic Cystitis	Pseudoneurotic Schizophrenia
Mrs. W.	58	\$32	1	Emphysema secondary to old Thoracoplasty Chronic Cystitis	Depressive Reaction Passive Dependent Personality
Mrs. S.	58	\$55	2	Diabetes Mellitus Chronic Cystitis	Passive Dependent Personality Psychophysiological Gastrointestinal System Reaction
Mrs. P.	67	\$92	3	Idiopathic Hepatosplenomegaly Osteoarthritis Congestive Heart Failure— compensated	Pseudoneurotic Schizophrenia

and all were accustomed to hard work from an early age. Without exception their fathers were described as strict disciplinarians, demanding and getting strict obedience. They pictured their mothers as sickly, and all had spent much time caring for them while they had been ill. The onset of somatic complaints in the patients was found to have begun at least as early as the menarche and all but one, Miss E., had married by age 22. Escape from hard work and strict parents were given as the reasons for marriage by all of the patients.

Their present life situations also showed similarities in addition to those indicated in Table I. Only Mrs. W. was not living with a supposedly incapacitated sickly spouse or relative. Her husband had died a number of years previously, following a lengthy illness, and she lived alone.

The similarity of primary concern, of course, is the patients' chronic somatic complaints. These somatic complaints served a number of important dynamic functions in the patients' lives. The most obvious of these are listed below and were

shared by all patients in the group:

(1) As a means of relating to people and as a reason for withdrawing from people. "I hate to go see anybody because all I got to talk about is my ailments."

(2) As an excuse for maintaining a dependent type of existence. All patients obviously used somatic complaints to get out of work and to retain their welfare status.

(3) As a means of expressing "psychic hurt." It could be demonstrated repeatedly in the sessions that somatic complaints were exacerbated and served the purpose of expressing the fact that they had been hurt in their relations with people.

(4) As a means of expressing hostility. "My husband hasn't had a bit of sleep all week since I've been hurting so bad at night."

(5) As an excuse for expressing hostility. "I wouldn't have acted that way if I hadn't been feeling bad."

(6) As an act of expiation. "I felt so bad about being so mean that I suffered all day."

(7) As a defense against hostility. "I told him I was too sick to be treated that way."

These, of course, do not cover all the functions served by these somatic complaints but represent only the most outstanding ones.

TREATMENT

As indicated in Table I, all of the patients carried organic and psychiatric diagnoses. Some of these disorders required continuing pharmacological treatment. Tranquilizers were continued where already in use and additional drugs of this type were prescribed for two patients, Mrs. P. and Mrs. J., during several episodes in which they were rather acutely disturbed. Treatment of episodes of urinary tract infections, URI's, gastroenteritis, etc., was necessary from time to time.

As mentioned, some attention was also given to the patients' reality problems. For instance, when it was discovered that one patient was collecting "pop bottles" in order to get bus fare to the clinic, transportation was arranged. As a rule, however, such tendencies towards independency and initiative were encouraged. Contact was kept with the local welfare department regarding the patients and their economic problems.

Focus was placed on the common psychopathological functions of the patients' somatic complaints, the more individualized pathological dynamics. However, because of the patients' generally low intellectual levels, meager education, and lack of psychological sophistication, insight was not a primary goal of psychotherapy. The group approach was used primarily because of the generally recognized therapeutic value of groups in the areas of mutual support and reassurance.¹⁻³ One of the primary reasons for placing this type of patient in a group had been the observation by the authors and others that these patients not only attended the clinic frequently, but came early and stayed late, spending long hours in the waiting rooms in conversation with other patients who were very similar to themselves.

Even though insight was not a primary goal of the psychological approach it was, however, always attempted. The following are some of the areas that were focused on:

(1) Giving the patients insight into the connections between interpersonal difficulties and their somatic complaints.

(2) The recognition of unconscious hostility.

(3) The ability to accept hostile feelings in themselves and others. This involved particularly dealing with the patients' strong tendencies to dichotomize: Love-hate, good-bad, etc. In connection with this, the patients were urged to be more willing to express and accept hostility in the group.

(4) An understanding of some of the areas of conflict that led to difficulties in interpersonal relations and therefore hostility. Some of the similarities in the patients' backgrounds and present life situations have already been mentioned. The patients, therefore, tended to have remarkably similar dynamics underlying their difficulties in relating to people and their subsequent resort to somatic complaints.

(5) Concomitant with these therapeutic endeavors, attempts were made to help the patients accept some dependency and assume some interdependency as the reality factors seemed to dictate.

RESULTS

Although some progress was made toward achieving insight, undoubtedly most of the benefit derived was from the mutual support and reassurance of the group.

An unsolicited remark made to one of the authors by a clinic nurse seems to document this. "Sitting in the waiting room they are like a girls' club talking to each other. They seem different." The mutual support given by the group to its members cannot be over-emphasized. For instance, when one member claimed to have had nothing but bread to eat for 48-hours, she immediately received an invitation to "come over for stew" from one of the more withdrawn members. Similar episodes were frequently repeated.

Some progress was also achieved in realizing insight. This was mainly in areas 1 and 2, as outlined above. For instance, one patient who frequently would cry out, wring her hands and pace the floor in pain was soon routinely asked during these episodes, "Who has been treating you mean this time?"

Some progress was also made towards insight in area 3, but here strong, possibly culturally determined, resistances were met. Frequently heard statements included: "As you think, so are ye." "Be ye kind one to another." "I turned the other cheek." "You'll go straight to hell if you keep getting mad like that."

Area 4 and the area of dependency-independency were hard to evaluate. Some degree of increasing independency was, however, undoubtedly seen in the patients. For instance, Miss E. was able for the first time in her life to go to town by herself and Mrs. W. was able to accept a reduction in her welfare check with no exacerbation in her symptoms.

There was a decrease of some 20% (\$592 to \$460) in the cost of medications for the group in the ten-month period immediately preceding group psychotherapy. Table II indicates a reduction of approximately 20% in physician hours spent with the patients. There was a 40% reduction in physician hours in clinics other than the psychiatric clinic. It should be mentioned that the average attendance of the patients in the group was 90%.

It is felt that the reduction in drug cost and total physician hours reflect, to some extent, the diminished somatic complaints of the patients during the ten-months of group therapy as compared with the ten-month period immediately preceding group therapy.

DISCUSSION

Other papers have considered the proper size of groups, the values of homogeneous versus heterogeneous groups, multiple therapists, etc.^{4,5} and these points will not

TABLE II

Physician Hours Spent with Patients in the Group Before and During the Group

Patient	Ten Month Period Prior to Group		Ten Month Period of Group	
	Medical	NP	Medical	NP
	Surgical		Surgical	
Miss E.	4	8	2	6
Mrs. W.	2	13	1½	6
Mrs. P.	4	8	4½	6
Mrs. R.	6½	4	2½	6
Mrs. S.	7½	6	8½	6
Mrs. J.	13	0	2½	6
Total	37	39	20½	36

be discussed here. It should be mentioned, however, that it was felt that the closer cooperation of an internist would have been quite beneficial.

As indicated earlier, it is likely that these patients can never be terminated from the clinics. This is true for several reasons. They are in an age group where organic geriatric illnesses occur. Their use of somatic complaints is a lifelong pattern which is, therefore, quite difficult to change. For some, coming to the clinic represents one of the few opportunities to get away from home and the responsibilities of their sick spouses for a few hours. To do this, they must be "sick." The goals of treatment, therefore, must be rather limited. To repeat, the purpose of the group is not to "cure" these patients but rather in as economical a way as possible over a long period of time, to enable these patients to make a better adjustment.

That continuing treatment is necessary was vividly demonstrated by what occurred after the ten month period ended and the therapists were being changed. It was not possible during this time for anyone to follow the patients closely. Mrs. P. proceeded, with a chief complaint of pain in her chest plus some equivocal objective evidence of organic disease, to get herself admitted to the hospital by some-

one unfamiliar with her. Needless to say, after two weeks of expensive laboratory and other diagnostic procedures, no organic basis had been found.

SUMMARY

Six chronic somatic complainers were treated over a ten-month period of time with a view towards a more economical therapy for treating the psychological difficulties that lead to the use of somatic complaints. It was found that while group therapy did not result in a discharge from the clinics, it did result in a savings in drug cost and physician hours. This is primarily because it is a better means of providing some of the psychological sup-

port and healthier interpersonal relationship that these patients really need.

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ON ERRORS IN PROGNOSIS

"Physicians should hesitate to try to take on the role of the Lord. It is well for us to be hopeful, if at times we must be cautious. It is best to keep the door a little ajar. If we err, it is better to err on the side of optimism. We are physicians, not prophets."

Dr. Samuel A. Levine—Medical World News, July 29, 1960.

Short Term Psychiatric Therapy

WILLIAM F. SHEELEY, M.D.*

After more than a half century of believing psychiatric therapy required either years on the couch or decades in the state mental hospital, physicians are coming to see that many psychiatric conditions can be adequately treated in the community and in a relatively short time. This new therapy concept stems partly from new specific therapies such as electroshock and the ataractic drugs, but also from better understanding of psychiatric disorders, treatment goals, and psychotherapeutic techniques.

Furthermore, today the layman is less rejecting and more sympathetic to the mentally ill. As people learn they need fear no more violent crime among the mentally ill than among themselves, they tolerate these patients on the streets, at work, and even in their homes. One can then use the community—instead of the sequestered mental hospital—as the locale of short term psychiatric therapy.

State legislators and other community leaders are seeing the real economy of intensive psychiatric treatment in the community rather than prolonged custodial isolation in a remote institution. These leaders note that an acutely ill patient stays much longer in a state mental hospital than on a general hospital psychiatric ward. They also note that adequate out-patient treatment facilities often help to avoid expensive hospitalization.

Community treatment of mental illness is also fostered by non-psychiatrists handling emotional problems in their offices. Psychiatric therapy depending entirely on psychiatrists will not be sufficient. The 600 newly trained psychiatrists each year would soon fail to meet the demand for

psychiatric therapy, even if that demand did not rise steadily, as other physicians learn to recognize hitherto undetected emotional problems. Finding psychiatric assistance inadequately available, physicians are looking to themselves to provide psychiatric therapy. They recognize their duty to provide short term psychiatric therapy.

New treatment methods for catching acute illness before it becomes chronic, furthermore, have aroused heightened interest in short term psychiatric therapy. Not always effective—acute illness even yet often becomes chronic despite therapy—these methods do lower the risk of chronicity and reduce the severity of psychiatric invalidism. Furthermore, these methods help avoid prolonged, psychologically debilitating institutionalization. In any case, fewer of today's acutely sick psychiatric patients ultimately require prolonged hospitalization.

Treated by intensive, short term therapy, patients respond in days and weeks instead of months and years. Thirty years ago, for example, the psychiatrist treating a patient with manic-depressive disorder had to watch sluggish, burdensome, and gloomy depression give way to frantic, staccato, excited mania, and revert back again to depression, unaffected by anything he could do. Then came electroshock therapy. He could not cure the disease, but he could at least bring relief. Another example is provided by the schizophrenias. As recently as ten years ago, many patients with schizophrenia, failing to respond either to electroshock therapy or to the more expensive and prolonged insulin coma therapy, had to stay in the hospital for decades awaiting an uncertain spontaneous remission. Now, with ataractic drugs, many therapeutically refractory patients are relieved in a few

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Presented at the Seventh Annual Meeting of the Academy of Psychosomatic Medicine, Philadelphia, Pennsylvania, October 14, 1960.

days or weeks of their hallucinations, delusions, and other distressing symptoms. Perhaps schizophrenic patients do not get well with chlorpromazine any more than cardiac patients get well with digitalis, but both mental and cardiac patients are living more useful and happy lives.

We are still committing many patients that should stay in the community, but comparatively fewer than we did. We have no statistics to compare the percentage of diagnosed mentally ill persons committed today with that of a few years ago. State hospital admission rates are rising, true, but new psychiatric services are being created in general hospitals all the time, and patients treated there usually do not need commitment. Perhaps, then, the *percentage* of recognized mentally ill persons committed is falling, even though the total *number* is rising.

Today's family physician has more community resources. He has better staffed social agencies to give special help and psychiatric wards in general hospitals. Business and industry are beginning to work with him to provide psychiatrically favorable working conditions.

Short term psychiatric therapy is now offered where formerly it was not even considered a psychiatric problem. For example, aged people with stubbornness, cantankerousness, and even confusion, mend quickly under a combination of drugs and supportive psychotherapy. Exasperating behavior disorders in children and juveniles disappear as the doctor treats child and parents. Psychosomatic disorders—often so severe as to threaten the patient's life—subside under a combined attack of psychiatric drugs, psychotherapy, and treatment of specific somatic illness. Even the shiftless ne'er-do-well (perhaps at bottom he has a mild schizophrenia) who has done nothing but sit around the house for years, can now often hold down a simple job. Emotional problems associated with child birth and the

menopause are found by Brougher¹ and others to respond to phenothiazines.

Short term psychiatric therapy, then, is here to stay, because it is needed and because it works. Because it often must be given by physicians other than psychiatrists, many physicians are eager to expand their psychiatric skills. They are finding, however, that psychiatric therapy is complex and highly individualized: It does not depend on what all psychiatric patients need, but on what this patient—the one in the office right now—needs. These needs depend on his particular personality, his present circumstances, and his past history. Furthermore, psychiatric therapy depends—more, perhaps, than any other medical therapy—on the personality and the peculiar capabilities of the physician himself.

The physician has, therefore, no cook book method for providing short term psychiatric therapy. The best way to acquire the complex skills needed is to take one of the postgraduate psychiatry courses offered in the community, or if none is offered, to agitate for one. However, perhaps we can here draw some useful general guide-lines for therapy:

Short term psychiatric therapy—like any other psychiatric therapy—includes the detection and correction of all concomitant physical defects and disorders in accordance with the ancient ideal of *mens sana in corpore sano*. The doctor takes a careful and complete medical history, does a thorough physical examination, and orders all appropriate laboratory procedures. He pays particular attention to the general level of health as revealed by such indicators as nutrition, blood hemoglobin level, and blood chemistries. He evaluates the patient's personal hygiene with reference to diet, tendency to get overly fatigued, over-demanding work, and excessive drinking or smoking.

Along with the medical work-up, the physician does a detailed psychiatric work-up, for the better he understands the

patient, the more accurate his psychiatric diagnosis, and therefore the more specific, rapid, and effective his psychiatric therapy. Hoff and Ringel² suggest that preparation for even brief psychiatric therapy must include the following:

1. Anamnesis from the patient himself.
2. History from others who know the patient.
3. Psychiatric (mental status) examination.
4. Psychophysiological examination.
5. Search for constitutional factors.
6. Evaluation of social conditions.

Many physicians also find it useful to request consultation by a clinical psychologist for appropriate psychologic testing.

Having come to understand the patient and his illness, the physician plans a tailor-made therapy program combining many different kinds of treatment, interrelated and balanced.

As he plans, the physician formulates explicit therapy goals; he then adheres to those goals until further experience with the patient justifies change. Without goals, the physician muddles along to the discouragement of patient and doctor alike. He sets realistic goals; he does not expect, for example, that a patient will function psychosocially at a higher level after therapy than he did before he became ill. Some possible therapy goals suggested by Kennedy³ are the following:

1. Relieved tension.
2. Removal of fundamental disabilities.
3. Improved use of mental potentialities.
4. Improved ability to solve problems.
5. Improved adaptation to circumstances.
6. Enough insight to prevent relapse.
7. Improved ability to take responsibility.
8. More positive attitude toward problems.
9. Broader reserve to meet future stresses.

Having determined his goals—what he is trying to do—the physician selects for each goal or set of goals that treatment method or methods most likely with this particular patient and in this particular situation to accomplish those goals. Kennedy also suggests some specific treatment methods:

1. Legal sanctions—including commitment.
2. Reprimand, moral lecture, and exhortation.
3. Direct suggestion.
4. Suggestion reinforced with a drug.
5. Reassurance.
6. Advice and counseling.
7. Supportive supervision.
8. Re-education.
9. Rehabilitation.
10. Re-socialization.

Such therapies as electroshock can be combined with these methods.

As the physician moves forward on a broad therapeutic front without losing sight of details, what general therapeutic viewpoints and principles might he adopt?

For one thing, the physician can adopt a policy of treating acute psychiatric illness in the community as far as possible. Rather than quickly recommend commitment, the physician can hospitalize him in a local mental hospital or on a psychiatric ward of a general hospital. Experience has shown that the more acute, violent, and dramatic a patient's psychiatric symptoms, the quicker his recovery and the fewer the sequelae of his illness.

To start the treatment itself, Ballin⁴ suggests the physician explore with the patient his present life situation, especially as it affects his psychiatric symptoms. As an out-come of such exploration, and following conferences with the patient's family and friends, Rapoport⁵ seeks to improve specific patient-environment interactions, by means of planned environmental manipulations carried out in cooperation with employer, family, so-

cial agencies, and other concerned persons in the community.

The physician can obtain psychiatrist help for his patient. An attractive physician-psychiatrist working arrangement is suggested by Eichhorn.⁶ Pointing out that all too often a patient is simply bounced back and forth from physician to psychiatrist in a disconnected way, he suggests they treat the patient together. Under this plan, each therapist contributes what he does best in such a way as to support what the other is doing. For example, psychiatrist and family physician may decide jointly that a depressed patient needs a combination of electroshock therapy, antidepressant drug therapy, and environmental manipulation which includes minor psychotherapy of selected family members. As the psychiatrist starts electroshock therapy, the family physician starts antidepressant drugs and psychotherapy. Having completed electroshock therapy, the psychiatrist gradually stops seeing the patient, while the family physician assumes major responsibility for therapy. Calling the psychiatrist as needed, the physician continues therapy as long as it is needed. This kind of psychiatrist-family doctor arrangement can be employed with the patient in the hospital during part of the treatment.

Family physicians are finding that new psychiatric drugs used with appropriate knowledge and caution are a major buttress of short term psychiatric therapy. One should note the caution of Moldenhauer,⁷ however, in regard to stupefying drugs such as bromides, barbiturates, and meprobamates. These sedatives blur unpleasant facts in the patient's life and thereby abet flight from reality. A temporary respite may be a good and necessary part of the treatment process, but the doctor must remember that psychiatric patients—often most reluctant to face their troubles—may use such drugs intemperately. The caution does not apply to

the ataractic drugs (such as the phenothiazines) and most of the antidepressants, which do not seem to have this seductive quality. In my own experience with a variety of these latter drugs, I have in no instance feared that a patient was becoming habituated.

One should not only treat physical disease and give specific psychiatric therapy, but also help the patient establish a healthful life routine. The psychiatrically healthy person characteristically follows a fairly rigid routine. He often complains that he is in a rut, that circumstances such as the necessity for making a living and meeting family and social obligations impose this routine on him; he may see the routine as an obstacle, rather than as an aid to mental health. Nonetheless, from this routine he gets form and substance for his life. By contrast, the mentally ill person usually has lost this form and substance. He drifts about without cardinal directions, without goals, without a solid system of values. In the mental hospital he finds these patterns in the hospital's rigid, dawn-to-dusk routine. In his physician's office he gets a prescribed, explicit schedule of daily activities. (The family can help impose this schedule.) As the patient becomes able to reassume responsibility for his own life routine, the physician makes the activities schedule more and more liberal until the patient finally resumes full charge of himself. Meanwhile, the physician helps the patient find more gratifications in life—in his job, in his immediate family, and in his social circle. The physician's goals are to divert the patient's attention from himself and to pull the fragments of his personality back together again.

As with every other therapy in medicine, the success of short term psychiatric therapy depends largely on the skill of the doctor. Now, this skill has no ceiling; none of us need wail, like Alexander, that there is no more psychiatric knowledge

to conquer. The more psychiatry one knows, the more he sees yet to be learned. Nevertheless, most physicians taking postgraduate psychiatric training are pleased to find how soon they learn to help emotionally disturbed patients.

Let me amplify my earlier suggestion that the physician continue to expand his psychiatric skills by regularly attending postgraduate courses. These courses seem to fall into two general types: The one type lasts not more than a few days, depends primarily on the lecture or panel teaching method, and is given to large classes of thirty to more than a hundred students. The other type extends over a period of from six to twenty weeks, uses the small group discussion teaching method, and is given to small classes of from six to fifteen students. One cannot say one of these types of course is superior to the other; each is useful when employed correctly.

The physician interested in postgradu-

ate psychiatric education should enquire as to whether a course is being offered in his community. If none is being offered, he can help get one started by working with such organizations as his county medical society, an American Psychiatric Association District Branch, a state or private mental hospital, the psychiatry staff of a general hospital, or the Mental Health Committee of his state's chapter of the American Academy of General Practice.

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In Atlanta, the city has no public beds for the mentally ill, but just built a new \$500,000 monkey house.

Dr. William Rottersman, Atlanta, Georgia.
(Quoted by A.P.A. Newsletter, Dec. 1959.)

Acute Confusional States in the Elderly

NELSON G. RICHARDS, M.D.

The elderly patient with an abnormal mental state presents problems in diagnosis and management. The evaluation of his mental status may be perplexing and time consuming. It is far too easy to relate various mental deficits, with the loss of the ability to think quickly, to the all-encompassing terms of *senescence* and *senility*. Since the abnormal state may be recent in onset, and the condition, therefore, possibly reversible, it is of paramount importance to attempt early recognition of the etiology and to institute the proper treatment immediately.

Description of the Acute Confusional State

The acute confusional state is known by many synonyms: acute brain syndrome, exogenous psychosis, toxic delirium or psychosis, acute organic mental syndrome, toxic confusional state, and the dysergastic reaction. These states are defined as "the result of temporary, reversible, diffuse impairment of brain tissue function. The basic disturbance of the sensorium may release hallucinations, poorly organized, transient delusions and behavioral disturbances of varying degree."¹

A delirium, or an acute confusional state, is characterized by cloudiness of consciousness, restlessness, fear, diminished awareness, illusions, hallucinations, delusions, and paranoid misinterpretations.

The degree of cloudiness varies constantly. These patients' attention spans are very short. They readily sink back into the confusion from which they have been partially aroused. Thought processes are labored and concentration is difficult.

Disorientation increases with deepening confusion. Memory for recent events is poor. Verbal problems requiring retention and simple calculation are poorly done. Restlessness with tremor, tossing, turning, searching, or picking movements is very common. Anxiety and fear may be quite marked, or the mood may be dulled and awareness of surroundings decreased. Confabulations demonstrate suggestibility and readiness to agree with the examiner.

Visual hallucinations are very common, frequently appearing as a pantomime that the patient is observing. These may be frightening and grotesque. Objects in their surroundings are often misinterpreted, especially when the patient is left alone in a semi-darkened, unfamiliar hospital room. Less commonly they have auditory hallucinations which are threatening or concern plots for their destruction. Conversations and other sounds in the hallway are misinterpreted at times as fearful and at times as the voice of a loved one, who is loudly summoned by the patient. Tactile sensations of bugs crawling over their skin or of being burned may occur. Paranoid misinterpretations are transient and poorly systematized. Doubt and suspicion may lead to a fear of being killed or persecuted. Patients with these paranoid misinterpretations may respond readily to reassurance. However, the patient may attempt suicide to escape the fearful situation.

The physical signs may include a sluggish reaction of the pupils, diplopia, and nystagmus. Incoordinated movements and slurred speech are further manifestations of their toxic state.

Differentiation of Acute and Chronic Confusional States

Three of the more common abnormal mental states in the elderly are the senile

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psychoses, the arteriosclerotic psychoses, and the acute confusional states. Patients with the senile psychoses have histories of gradual and continuously progressive degeneration of personality and intellect. In patients with arteriosclerotic psychoses, mental changes develop step by step, and are usually associated with cerebrovascular accidents of varying severity and frequently with focal neurologic sequelae. The acute confusional states, on the other hand, develop in hours, days, or weeks, and are characterized by clouding of consciousness in the absence of previous dementia or personality change.

The differentiation of the acute from the chronic confusional states rests mainly with the history and the duration of altered mentation. In the chronic state the disorganization is one of slowly progressive dementia, with loss of mental faculties and flexibility, and with social inappropriateness. The patient may become neglectful of personal appearance to the extent of incontinence. The previous lifelong personality traits are exaggerated; i.e., a dependent person becomes more dependent, a suspicious person paranoid, and a garrulous person even overtly aggressive.

It should be emphasized that a patient with either a senile or an arteriosclerotic psychosis can have a superimposed acute confusional state.

The importance of early recognition of the acute state is that it may be relieved promptly by the early institution of appropriate treatment. The need for promptness was emphasized by Hill,² who wrote: "Any acute confusional state lasting more than a few days is always a serious disease in the elderly, a fatal issue following in about 50%." When the mental condition begins to improve, if only intermittently, during the first two or three days, the prognosis is relatively good; however, when the acute delirium lasts for as long as ten to fourteen days, the prognosis is far more guarded.

Etiology

The acute confusional state in the elderly may be secondary to a large variety of general medical disorders, e.g., cardiac failure; febrile illnesses; intoxication; postoperative conditions; anemia; and hepatic, pulmonary, or renal failure. The extrinsic causes may be either physical or chemical.

Intolerance to high temperature and humidity frequently causes the syndrome of heatstroke in the aged patient. This usually occurs during the first few days of a "heat wave." The body temperature suddenly rises; the skin is hot and dry, and may be either flushed or dusky gray. Alertness may vary from delirium to coma. With the exception of the rare intracranial lesions that can cause temperatures as high as 108° F. or above, weather is the most frequent cause of high fevers in adults. The treatment is the rapid reduction of body temperature, most quickly accomplished by ice water tub baths. Heatstroke has a high mortality if it is untreated.

Subdural hematoma secondary to recent or remote head trauma may result in headache and altered mental function. The cerebrospinal fluid obtained by lumbar puncture usually demonstrates elevation of the protein concentration and xanthochromia. The trauma may be so remote that it cannot be recalled by the patient or by his guardians. Unsuspected subdural hematomas are occasionally found at necropsy.

Various chemical agents can be the cause of cloudy thinking and disorientation. These agents include some of the drugs used in the treatment of the elderly, the most common being bromides, belladonna, and barbiturates. An elderly patient who has received a hypnotic drug may become acutely agitated, frightened, and confused. Poisons must also be considered; however, most of these produce other physical symptoms and signs that are more specific. Benzene, carbon tetrachloride, lead, carbon monoxide, and ethyl

and methyl alcohol lead the list of those producing changes in mentation.

Poor dietary habits and vitamin deficiencies may also result in toxic confusional states.

Treatment

The treatment of the acute confusional state begins with the treatment of the underlying cause. Along with this specific treatment, the acutely disturbed patient needs special attention—not restraints. He is usually most confused at night, and therefore, sedatives in amounts sufficient to allow sleep are of utmost importance and should be adequate to carry him through to the daylight hours. During the daytime he should be awake and unseated. Since the patient may be quite excited or frightened, the presence of someone he knows well may be of great aid and assistance in management. Accidental injury or suicide may occur during attempts to escape the illusions or hallucinations. Therefore, early hospitalization is desirable. If he is placed in an unfamiliar room with curtains, fans, air conditioning vents, and other paraphernalia that allow for misinterpretations while consciousness is clouded, the constant reassurance of a familiar face or voice will aid in reorien-

tation. Relatives or a nurse whom he knows well should constantly reassure him as to where he is and what has happened, and should reassure him that his condition will improve. Giving this reassurance may become monotonous, but it is an extremely important part of the attempt to reorient the agitated, confused patient. Prompt, effective, general and specific treatment, as well as the quality of nursing care, will in large measure determine the outcome, for the longer the confusional state lasts, the worse the prognosis becomes.

SUMMARY

It behooves us all to be alert to the manifestations of acute delirious reactions in the elderly. In the absence of general medical disorders contributing to the delirium, a search should be made for an extrinsic etiology. If as soon as the diagnosis of an acute toxic confusional state is made, energetic specific and general treatment is instituted, the prognosis is good.

REFERENCES

1. *Diagnostic and Statistical Manual; Mental Disorders*. Washington, D.C.: American Psychiatric Association; Mental Hospital Service, 1952, p. 15.
2. Hill, D.: *Practitioner*, 174: 536-543, May 1955.

For keeping mentally healthy in the 20th century, my advice is to face difficulties as they come along. Don't let them pile up until you blow up.

Dr. Douglas Bond, Western Reserve Univ., Cleveland.
(Quoted in Wesleyan Methodist.)

Tranylepromine and Trifluoperazine in the Treatment of Psychosomatic Complaints

W. C. MARKSFIELD, M.D.

In my practice, there is a wail of psychosomatic complaints arising from patients who are both depressed and anxious. Whether they are anxious about their depression or depressed about their anxiety probably doesn't matter. What does matter to them is that they are fearful, sleepless, tired, tearful, worried, bewildered. Most of them are women, but not all. Most of them don't seem able to respond adequately to reassurance and counseling; all fare badly on admonishment.

In such a group of 56 patients I recently evaluated a combination of 1 mg. trifluoperazine and 10 mg. tranylepromine, a tranquilizer and an antidepressive. There were 39 women and 17 men from 18 to 67 years old; they averaged 39 years. A partial list of their complaints would include vague aches and pains in practically all parts of the body, dizzy spells, dyspepsia, abdominal discomfort, constipation, diarrhea, and heartburn. In addition, all complained of various mental and emotional symptoms of depression and anxiety. They were chronically fatigued ("I just can't seem to get started, Doctor"), nervous ("I can't sit still"), tearful ("I don't know, just the smallest things make me cry like a baby"), irritable ("I'm always snapping at my wife and children"), worried and overconcerned about relatively minor matters, sleepless, bewildered, and afraid. A few patients reported loss of appetite and weight, or compulsive eating and a rapid gain of weight. These symptoms had persisted for from several months to several years, and clinical evaluation had excluded organic pathology as a basis for them.

The usual starting dose was one tablet twice a day except for one patient who received one tablet before retiring

throughout the evaluation, and another who received one tablet a day at the beginning of treatment and then two a day. As treatment continued, the dose was reduced to one tablet a day in twelve patients. Treatment was continued until side effects interfered or until it seemed the patient no longer needed the drug. As of this writing, except for four patients who stopped taking the drug because of side effects, treatment has been continued for from 3 to 22 weeks (average 6 weeks); 15 patients are still receiving the drug.

RESULTS

Evaluation of improvement was based on changes in psychosomatic symptoms and in mood. Where the incidence and severity of somatic complaints were greatly reduced or eliminated, and when nervousness, insomnia, fatigue, and the other symptoms of mental distress were relieved completely or almost completely, improvement was graded as marked. Of the 56 patients treated during this evaluation, marked or complete improvement occurred in 34, with some improvement (probably what one could expect from a placebo, plus reassurance) in 16, and none at all in six.

Ordinarily, improvement, when it occurred, was noticeable within the first week of treatment and became optimal within two or three weeks. The drugs were usually discontinued when the patient had remained symptom-free for two or three weeks. In about one third of the patients, however, symptoms recurred within two weeks after the medication was stopped. Then treatment with the combination was restarted, and the patients again reported improvement—less pain, fewer attacks or dizziness, and a reduction of gastrointestinal discomfort

and other psychosomatic complaints. They also said that they felt less tired or nervous, and that their appetites were more "normal." In short, patients tended to return to their premorbid or "normal" state. For example, improvement was considered marked in a 49-year-old man who complained of backache, constant tiredness, and resultant irritability and belligerence. He stated that he had no trouble sleeping but never felt refreshed when he woke up. No organic disease could be found. These symptoms had been present for six months and had been relieved slightly by treatment with pentobarbital. Treatment with the combination was begun with doses of one tablet, two times a day. He was seen a week later, and reported that his back was not bothering him as much as it had, and that he was less tired and better able to take care of his duties. Treatment was continued at the same dosage for one month. At this time, he reported that his backache had completely disappeared, he no longer felt abnormally tired, and he no longer "snapped" at his family and friends. He was able to concentrate on his studies and to perform them much better. His improvement has been maintained for the four months on a dosage of one tablet a day.

Another example of marked improvement was seen in a 58-year-old menopausal woman experiencing nervousness, easy excitability and fatigue, irritability, insomnia, headache, and vague gastrointestinal disturbances. Treatment was begun with one tablet, twice a day, and has continued for seven weeks. During the first week, she reported she felt much better and was able to get a good night's sleep for "the first time in months." Since then, she has experienced a complete elimination of all symptoms of psychic distress and is no longer overconcerned with or overaffected by the normal physiologic changes that continue to occur.

Treatment was considered unsatisfactory in a 44-year-old woman who complained of dizziness, tension, and a general feeling of sadness and melancholy. Ten days after treatment with one tablet twice a day was begun, she reported a severe, band-like headache that disappeared only when treatment was discontinued. Results were also considered unsatisfactory in three other patients in whom side effects were relieved only by discontinuing the drug, and in two patients who experienced no apparent relief of symptoms.

Side effects occurred in eleven patients altogether. Four complained of insomnia, four of headaches, two of vesicular skin eruptions (combined in one instance with loss of appetite), and one of constipation. Insomnia was relieved in three patients by reducing the dosage to one tablet a day and in the fourth by discontinuing the medication. In three the headaches ceased when the dosage was reduced to one tablet daily and the other when the drug was discontinued, as was mentioned above. In the patients with vesicular skin eruptions, the drug was discontinued and the rash cleared. The one case of constipation subsided without a reduction in dose.

SUMMARY

Fifty-six patients were given a preparation containing 1 mg. trifluoperazine and 10 mg. tranlycypromine, usually twice a day, for relief of a variety of somatic complaints associated with or stemming from depression and anxiety. Marked improvement was noted in 34 patients. Mild side effects, e.g., insomnia, headaches, and vesicular skin eruptions, occurred in eleven patients and either disappeared spontaneously, or were controlled by reducing or discontinuing the drug.

308 Fortieth Ave., Lachine, Montreal, Quebec.

Notes and Comments

Plans for an Edward Weiss Memorial

The late Dr. Edward Weiss made many invaluable contributions to the store of medical knowledge and was unselfishly active in the broad community. Many of his friends have resolved to perpetuate his memory by presenting an outstanding piece of sculpture to the Philadelphia Museum of Art in his name, in view of his deep interest in the arts.

Selected for presentation is a greater than life size bronze "Icarus in Descent" by Helaine Sardeau.

All those who were associated with Dr. Weiss are invited to send contributions, large or small, so that this project may be speedily completed. Checks should be made out to "Philadelphia Museum of Art—Edward Weiss Memorial," Benjamin Franklin Parkway and 26th Street, Phila. 1, Pa. All contributions are tax deductible. Any sums not needed for the sculpture will be used in other worthy projects for the furtherance of some phase of medical knowledge.

The June Meeting

Plans for the meeting on Sunday, June 25th, have been almost completed. The place is the Barbizon Room of the Barbizon Plaza Hotel in New York City; the date is Sunday, June 25th, which coincides with the opening sessions of the meeting of the American Medical Association. Entitled a "Symposium on Anxiety and Depression," the morning session will include papers dealing with the biochemistry of the tranquilizers and antidepressants, psychophysiological correlations in stress, and psychodynamic correlations in drug therapy. The potentialities as well as the possible pitfalls of psychopharmacology will be evaluated. The speakers include: Drs. Bernard Brodie, Fridolin Sulser, and Erminio Costa of the National Institute of Health, Bethesda, Maryland; Dr. Anthony Sainz, Director of Research, Marcy State Hospital, Marcy, N. Y.; Dr. Stanley Lesse, Attending Neurologist, Neurological Institute of New York and Editor of the *American Journal of Psychotherapy*; Drs. Joseph M. Tobin and Mark W. Williams, Bureau of Research, Princeton, N. J.; and Dr. Paul H. Hoch, Professor of Psychiatry, Columbia University College of Physicians and Surgeons and Commissioner of Mental Hygiene, New York State. Dr. W. Keup, Director of Research, Brooklyn State Hospital and Dr. Nolan D. C. Lewis, Director of Research, N. J. Neuropsychiatric Institute, Princeton, N. J., will lead the discussion.

The luncheon session will feature a talk by Dr.

T. A. Watters, Professor of Psychiatry, Louisiana State University School of Medicine. His topic will be "Experiences in Psychiatric Postgraduate Education of the Non-Psychiatrist." Discussants will include Dr. Phineas J. Sparer, Professor of Psychiatry and Preventive Medicine, University of Tennessee School of Medicine, and Dr. William F. Sheeley, Washington, D.C., Director of G. P. Education Project, American Psychiatric Association.

The afternoon session will include papers on current research in psychopharmacology. Speakers include Dr. Eugene Chesrow, Medical Superintendent, Oak Forest Hospital, Oak Forest, Illinois; Dr. Edwin Dunlop, Assistant Medical Director, Fuller Sanitarium, Attleboro, Mass.; Dr. Laurence Weiss, Albert Einstein Medical Center, Philadelphia; Dr. Burton Cahn, Chief of Administrative Services, Norristown State Hospital, Norristown, Pa.; Dr. Paul Feldman, Director of Research and Professional Education, Topeka State Hospital; and Dr. W. Stanley Welborn of University of Oregon Medical School.

Discussants for the afternoon papers include Drs. Henry Agin, Director of Neuropsychiatry, Beth-El Hospital, Brooklyn; Dr. Theodore Robie, East Orange, N. J.; and Dr. Carl Pfeiffer, Head of the Section of Pharmacology, N. J. Neuropsychiatric Institute at Princeton.

Programs should be available by May 15. For further information or for luncheon reservations, please write to the Editor at 1921 Newkirk Avenue, Brooklyn 26, N. Y.

Academy News Notes

YUJIRO IKEMI, M.D., Ph.D., Director of the Japanese Division of the International Society for Clinical and Experimental Hypnosis has become Executive Secretary of the recently organized Japanese Psychosomatic Society and will be the Editor-in-Chief of its new journal. Dr. Ikemi is a member of the Advisory Editorial Board of *Psychosomatics*.

DR. F. NEGRAO PRADO, Secretary of the Brazilian Society of Medical Hypnosis, has recently presented a series of courses in Clinical Hypnosis in Portugal. These courses were given in association with Professor Henrique Jao de Barahona Fernandez, Director of Clinical Psychiatry, University of Lisbon Medical School.

PROF. GEORGE YAHN of the University of San Diego, California, is currently engaged in a research project on psychoneurosis and crime.

PAUL SACERDOTE, M.D., of Mt. Vernon, N. Y., presented a paper on "The Place of Hypnosis in the Physiology and Psychology of Pain"

at the American Society for Clinical Hypnosis in New York.

BENJAMIN ZOLOV, M.D., recently published a paper on "A Clinical Evaluation of Cinnarizine (Mitrone) in Various Allergic Disorders" in the *Maine Medical Journal*. This material was also presented at the meeting of the American College of Allergists in Dallas, Texas, in March.

S. GEORGE BROWN, M.D., of Concord, N. H., has been reappointed State Chairman for Mental Health for the AAGP.

NATHAN W. COLEMAN, M.D., of Boston, Mass., has entered a full-time psychiatric residency at the Boston State Hospital.

JOSEPH J. FRIEDMAN, M.D., of Brooklyn, N. Y., was guest speaker at the Ocean Medical Society in January. His topic was "Hypnosis in Medicine and Psychiatry."

DR. MILTON V. KLINE is serving as psychological consultant to a hypnosis research project involving the effect of hypnotically-induced emotions on physiological functions. This work is being done at Grasslands Hospital, Westchester County, N. Y.

WILLIAM MUIR MANGER, M.D., of New York City, is currently engaged in research on cardiovascular shock secondary to hemorrhage. He recently presented a paper on "Transfusion Acidosis" at the N. Y. Academy of Sciences, and spoke before the Dept. of Pharmacology, University of Pennsylvania, on his work on the catecholamines and shock.

LEO WOLLMAN, M.D., of Brooklyn, N. Y., addressed the New Jersey Society of Clinical Hypnosis on "Hypnosis in Obstetrics and Gynecology" on March 22. He also spoke before the Alumni Association of the Brooklyn College of Pharmacy on "Hypnosis, A New Horizon" on March 28.

AVROHM JACOBSON, M.D., of Asbury Park, N. J., was recently appointed Professor of Clinical Psychiatry at the Seton Hall College of Medicine.

J. WESLEY EDEL, M.D., of Baltimore, Md., was recently elected to Fellowship in the American Society of Clinical Hypnosis.

WALTER S. FELDMAN, M.D., has given up his practice and is a resident in psychiatry at Michael Reese Hospital in Chicago.

MILTON H. ERICKSON, M.D., of Phoenix, Ariz., spoke on "Hypnosis in Psychiatry and Medicine" at the Philadelphia State Hospital in January. He also presented a paper on "Advanced Techniques in Hypnosis" before the Arizona Society of Clinical Hypnosis during January.

FREDERICK W. GOODRICH, JR., M.D., of New London, Conn., spoke before the Eighteenth Annual Medical and Surgical Symposium at Watts Hospital, Durham, North Carolina, in Feb-

ruary on the "Psychosomatic Aspects of Obstetrics."

BERTRAM B. MOSS, M.D., of Chicago, was a scientific exhibitor at the Indiana Academy of General Practice Scientific Session in March.

VICTOR SZYRYSKI, M.D., Ph.D., consultant in Mental Health to the North Dakota State Dept. of Health, spoke on "Some Psychiatric Syndromes in Internal Medicine" before the District Medical Society Meeting in Jamestown in January. In February, he spoke on "Parents and Children in the Light of Dynamic Psychology" and on "The Nature and Treatment of Epilepsy" at Valley City, and on the "Psychodynamics of Marital Difficulties" in Bismarck. He also participated in the "Institute on Mental Health and Pastoral Psychiatry" at St. Michael's Hospital in Toronto, in February.

KENNETH W. TEICH, M.D., of Duluth, was chairman of a Regional Meeting of the Academy of Psychosomatic Medicine, held at the Radisson Hotel in Minneapolis on February 15. The speaker was Wilfred Dorfman, M.D., of Brooklyn. The discussants included Richard Magraw, M.D., of the University of Minnesota Medical School, and Eugene Rinkey, M.D., of St. Paul.

FRANK AYD, JR., M.D., of Baltimore, presented a paper on "Comparative Clinical Experience with Antidepressants" at the Symposium on Depression held by the Eastern Psychiatric Research Association in March in New York City. Wilfred Dorfman, M.D., presented a paper on "Studies in Masked Depression"; Edwin Dunlop, M.D., of Attleboro, Mass., presented one on "Management of Depression in Private Practice." Theodore Robie, M.D., of East Orange, N. J., was a discussant.

MILTON M. BERGER, M.D., of New York, President-elect of the American Group Psychotherapy Association, announces that the Association for Group Psychoanalysis is offering a limited number of scholarships for its basic course in Group Psychoanalysis. For further information write Apt. 4B, 50 East 72nd St., New York 21, N. Y.

DESZO LEVENDULA, M.D., of Cleveland, is Program Chairman for the October 1961 meeting of the Society for Clinical and Experimental Hypnosis. (Meetings dates—Oct. 4 and 5, at Sheraton-Cleveland Hotel.) For further information, write to Dr. Levendula at 10900 Carnegie Avenue, Cleveland 6, Ohio.

Meeting Note

The International Congress of Psychosomatic Medicine and Childbirth, to be held in Paris, France, has been postponed until July 1962, according to Dr. L. Chertok, secretary of the Société Française de Médecine Psychosomatique.

Abstracted from the Medical Press

CIRCUMCISION AND ANTI-SEMITISM. Jules Glenn, M.D., *Psychoanal. Quart.*, 29:395-399, July 1960.

In recent years there has been some discussion as to the medical basis for circumcision, and in the large metropolitan areas, this surgery is more frequently carried out than in rural areas. This article, which reports the analysis of two clinical cases, illustrates that the anti-Semite may harbor contradictory attitudes towards Jews. Because the Jew is circumcised, he is held to be castrated and effeminate. For the same reason, he is feared and envied as being virile, aggressive, and castrative. It was the author's feeling that the productions of these two patients, showing conflicting prejudices, were projections of bisexuality. The analytical literature would generally indicate that the process of circumcision, when done in the pre-adult years, may mean "castration" to the individual.

James L. McCartney, M.D.

HYPNOTIC TREATMENT OF ASTHMA. Edwards, G., *Brit. Med. J.*, 5197:492-497, Aug. 13, 1960.

In this study, six patients admitted to the hospital for severe asthma were treated by hypnosis. Because resolution of mucosal edema and bronchial plugging is likely to take hours or days rather than minutes, hypnotic suggestions were given that the asthma would gradually disappear. Each session, which was repeated on several days, took 10 to 45 minutes.

Serial ventilatory function tests were made. Vital capacity and forced expiratory volume in one second were recorded. Forced expiratory volume in one second is the maximum air that a patient can expire in one second, starting from the full inspiratory position. Normally it should be not less than 65% of the total capacity. These patients on admission had between 30 and 40%.

In this study hypnosis was used on the assumption that the primary etiology of asthma is always somatic, but that the severity of this disease may be potentiated by anxiety, including anxiety about asthma. Hypnosis can be regarded as a means of reinforcing the strong element of suggestion that is present in "physical" forms of asthma treatment. The theoretical dangers of hypnosis have often been stated, but in a survey conducted among practising psychiatrists (Wolberg, 1956) few untoward effects were reported.

Dr. Edwards' conclusions are that hypnosis benefited a patient in one of two entirely different ways: either by effecting physiological improvement (decrease of airways resistance) or

by producing psychological improvement (decreased awareness of airways resistance).

Leo Wollman, M.D.

POST-MICTURITION SYNCOPE. George B. Prozan and Allen Litwin, *Ann. of Int. Med.*, 54:82-89, January 1961.

Three case histories are detailed involving syncope associated with micturition in healthy adult males.

The Valsalva maneuver, with its many variations, has commonly been associated with cardiovascular collapse. The dynamics involve an initial phase associated with straining and manifested by a rise in blood pressure and forceful expulsion of blood from the lungs into the left heart, increasing cardiac output. The second phase involves a marked fall in blood pressure and a narrowing pulse pressure associated with an increase in peripheral resistance and a diastolic rise. On release of the strain, a third phase relates to the absorption of the right ventricular output by the sudden expansion of the previous compressed vascular tree of the lung, thus momentarily further decreasing venous return and left ventricular output. A final phase includes the so-called "over-shoot" in which a second rise in blood pressure above control levels is caused by increased cardiac output and the maintenance of an increased peripheral resistance. Finally, this blood pressure elevation activates the carotid sinus and aortic arch reflexes, thus producing a diminution in peripheral resistance and a bradycardia.

The authors present evidence to show that these exaggerated reflexes with marked vagotonia combine to cause syncope. Electrocardiographic T wave changes and arrhythmias following a collapse were abolished by atropine, but the blood pressure changes were exaggerated with a marked "over-shoot." Thus it was also concluded that acetylcholine rather than changes in cardiac work mediated the abnormal response. Apparently, individuals subject to syncope associated with micturition are either hyper-secretors of acetylcholine as compared with the general population, or are hypersensitive to the effect of this substance.

Sanford M. Lewis, M.D.

NEW PSYCHOTHERAPEUTIC AGENT, CHLORDIAZEPOXIDE (LIBRIUM) Tobin and Lewis, *J.A.M.A.*, 174:10:1242, Nov. 5, 1960.

The authors report on a large collaborative study of 135 women and 77 men patients, who were treated with the drug. A favorable re-

sponse was reported in approximately 80% of the subjects. The initial dose was 25 mgs. once or twice a day, which was increased gradually until some patients received a total of 175 mgs. per day. The usual maximum daily dose ranged from 10 to 150 mgs. The authors remarked about the freedom from side effects on the extrapyramidal system. They also felt that phobic reactions, obsessive thinking, compulsive behavior, depression, tension, psycho-motor and motor retardation, hysterical acting-out, and conversion reactions reacted favorably to chlordiazepoxide.

Laurence Weiss, M.D.

GAUGING DOSAGE AND DISTANCE IN PSYCHOTHERAPY WITH ADOLESCENTS. Paul A. Zwick, M.D., *Amer. J. of Orthopsychiat.*, 30: 3:645, July 1960.

The adolescent, resistive in treatment, is seeking distance between himself and the adult world. He may be antisocially pushing against his world or asocially pulling away from it. The therapist is usually a source of anxiety. To avoid early breakdown of therapy one must be perpetually sensitive as to how close or how distant the relationship needs to be fashioned to establish and maintain rapport. The author believes an initial phase of quick meaningful engagement, in which the therapist is unusually active, may be followed by a long phase of reduced contact. In the first phase, interviews take place once or twice a week; in the second phase they may be three to six weeks apart. The following measures were found helpful in the first interview:

- 1) The therapist voices his full respect for the patient's autonomy.
- 2) The therapist deflates the image of his own omnipotence by admitting his own helplessness in the face of the patient's strength.
- 3) The therapist offers his readiness to assist the patient toward greater self-understanding.
- 4) The patient is given the choice to risk or refuse further interviews.

The patients were most comfortable in using the therapist as another peer who was understanding of their needs for rebellion. The author feels this limited contact approach in individual therapy should be validated. He feels this dilution and diffusion of the therapist's impact is a tool now largely used in group therapy with adolescents. Both approaches offer preservation of a modified contact with the therapist, de-emphasis of dependency needs, and stress on adequacy.

Joseph Joel Friedman, M.D.

FETAL DAMAGE DUE TO ECT, INSULIN COMA, CHLORPROMAZINE OR RESERPINE. David E. Sobel, M.D., *A.M.A. Arch. Gen. Psychiat.*, 2: 6:606-611, June 1960.

This interesting paper discusses the effect of somatic psychiatric therapies on the newborn. The author studied 110 cases who were treated while pregnant and delivered in eight New York state mental hospitals during the period of 1949 through 1958. Another 202 non-treated women who were pregnant, delivered in the same hospitals during the same period of time and were used as a control group. The results of his investigation show that electric shock administered to pregnant women does not increase fetal mortality or morbidity. Electric shock may precipitate antepartum complications such as vaginal bleeding and abdominal pain in about the eighth month of pregnancy. There was no incidence of premature birth or abnormal presentations. The developmental history of children born after this form of treatment revealed no abnormalities.

The incidence of fetal damage in a group of seventeen pregnant women treated with insulin coma therapy was 35.5%. Pregnancy is a contra-indication for insulin coma treatment, according to this author.

Chlorpromazine does not raise the incidence of fetal mortality or morbidity when administered to pregnant women. However, pregnant women who take 500 mg. or more of chlorpromazine during the latter part of pregnancy may have newborn children who suffer from respiratory distress.

While other authors have reported excessive nasal congestion with cyanosis, costal restriction and lethargy, with the use of reserpine, the present author was unable to confirm these findings with his study of fifteen cases.

Theodore Rothman, M.D.

IMAGINARY SEXUAL PARTNER — VISUAL MASTURBATION FANTASIES. N. Lukianowicz, M.D., *A.M.A. Arch. of Gen. Psychiat.*, Vol. III, No. 4, Oct. 1960.

This paper inquires into the masturbatory experiences of 188 patients with special emphasis on accompanying visual fantasies. It classifies and describes clinical variations and attempts to explain etiology and psychodynamics. A brief review of the literature is presented.

Masturbation, the author states, is a universal practice. It may be a "symptom of a neurosis, but it does not create a neurosis." In children, adolescents and in some young adults who are temporarily deprived of heterosexual opportunity,

masturbation may be considered normal. If it replaces the normally acceptable heterosexuality, it is pathological. Most males and many females experience erotic visual fantasies during the act of masturbation. They provide an imaginary partner and when the real one appears, the mechanism usually disappears since it is no longer necessary. The contents of these fantasies include the normal heterosexual or the abnormal homosexual partner. In other deviate forms, it may be the fetishistic or zoophilic object.

Men are probably more prone to these masturbatory fantasies than are women. No causal relationship exists between them and psychiatric illness. Intelligence and the capacity for visual imagery contribute to the development of these fantasies. In theory, masturbatory equivalents include kleptomania, pyromania, gambling and drug addiction. All are forbidden acts.

Therapy is to be directed to the psychiatric disorder and best results were obtained in reactive depression and obsessional neurosis. In some cases, masturbation must not be stopped since it serves as an important discharge of aggressive and sadistic impulses. Young subjects without mental disorder should receive correct information about masturbation in order to clear up misconception and prevent the development of a secondary neurosis.

George J. Train, M.D.

THE INFANT'S EARLIEST MEMORY OF INOCULATION: A CONTRIBUTION TO PUBLIC HEALTH PROCEDURES. David M. Levy, J. of Genetic Psychol., Vol. 96, First Half, March 1960, pp. 3-47.

Fears conditioned by immunization of young children may be generalized into fear of any contact with a physician and any building that resembles a hospital. The fears may be extended to coats, and thus to barbers and hair-cuts.

For this careful investigation 2,000 records were gathered in New York City public health stations. The purpose was to find a "safe period," a particular age in infancy, during which inoculations would not be remembered by the child. The series included seven such experiences. Criteria were based upon the infant's "memory cries," with consideration for such other variables as examination room conditions, mother's attitude, and schedule of immunization.

From the findings the author concludes that inoculations given at six-week intervals and completed by six months of age are most unlikely to be remembered. The fact that these are not remembered leads to the inference that they furnish no source of anxiety for later events in life. Thus the method of completing immuni-

zation by six months of age to be followed by booster shots after intervals of more than two months appears to be psychologically the best procedure.

Elizabeth Thoma, Ph.D.

PSYCHOSOCIAL ASPECTS OF HEMOPHILIA: A STUDY OF TWENTY-EIGHT HEMOPHILIC CHILDREN AND THEIR FAMILIES. Browne, W. J., Mally, M. A., Kane, R. P., *Am. J. of Orthopsychiat.*, 30:730-740, Oct. 1960.

The authors describe their observations pertaining to the patient's conflict about physical activity, its relation to bleeding episodes and the source of this conflict in the mother-child relationship.

The study shows the presence of causal relationship between emotional factors, spontaneous bleeding and increased accidents. Spontaneous bleeding is more frequent, although milder, than the less frequent but more severe traumatic bleeding.

The desire of the child to be active and aggressive is inhibited by the overprotective mother to avert the dangerous effects of injury. To be accepted, the child must become submissive and passive. He may equate independence with separation from the mother. Guilty about her role as the carrier of the disease, the mother must take responsibility for all of the child's care and management; this very close mother-son relationship relegates the father to an inferior role and produces criticism and resentment. His reactions may be decisive in the nature of the child's identity. The specificity of the different roles of the mother and father in this illness is caused by the special nature of heredity in this illness.

These dynamic factors must be considered in the therapeutic approach. The mother's guilt as the carrier has to be alleviated; she must become aware that bleeding does not follow every trauma, that an overprotective attitude may not prevent bleeding, and that emphasis should be placed on training the child to take care of himself rather than on restrictions. The father should be included in the active role of the family affairs.

A psychotherapeutic approach appears to decrease the frequency of hospitalizations due to severe bleeding.

Adam J. Krakowski, M.D.

NEUROSIS IN THE FAMILY. Jan Ehrenwald, M.D., *New York A.M.A. Arch. Gen. Psychiatry*, 3:233-242, Sept. 1960.

The present theory of psychiatric epidemiology assumes that maladjusted attitudes, rather than specific nosological entities are subject to psychological contagion. It is the pattern of con-

tagion such as the sharing of socially undesirable traits and attitudes that spreads and envelops all aspects of family and community interaction. The author's study suggests that: (1) Psychological contagion may be conducive to the development of similar or of dissimilar clinical symptomatology, (2) psychological contagion is proportional to the duration of exposure and inversely proportional to the age the exposure takes place, (3) psychological contagion is determined by the individual's susceptibility and resistance to it.

Bertram B. Moss, M.D.

HYPNOSIS AND THE OBSTETRICIAN-GYNECOLOGIST. F. P. Zuspan, M.D., *Obstetrics and Gynecology*, 16:6, Dec. 1960.

Despite current controversy concerning hypnosis, it has a definite place in obstetrics-gynecology and should be used where indicated. There are three basic requirements: (1) The physician must be trained and confident. (2) The patient must be receptive, motivated, and confident. (3) The use of hypnosis must be flexible and satisfy the general as well as the specific needs of the patient. Deep trance is not necessary and the doctor should be satisfied to work at any level. Hypnosis is especially valuable in five states encountered in this specialty: Chronic pain in terminal carcinoma, hyperemesis, urinary retention following surgery, poorly motivated recovery after surgery, and intractable dysmenorrhea.

F. W. Goodrich, Jr., M.D.

EUGENIC STERILIZATION. Morton Birnbaum, LL.B., M.D., *J.A.M.A.*, 175:11:951, March 18, 1951.

One of the social problems which plague practicing psychiatrists, is the patient who should be sterilized.

The author discusses the legal, medical and moral aspects of present practices in public mental institutions. He specifically refers to the sterilization of a mentally disordered person who is mentally ill or mentally defective because of heredity and/or environment. He points out the wide disparity between the states where some keep the patient in hospitals throughout the childbearing period, while others do a rapid study and discharge the patient. In adjudicating such a case in Virginia, he states, "In interpreting any legal decision in any field of law, especially such an emotion laden field as eugenic sterilization, it would be well to remember the very simple, but very true admonition of a distinguished constitutional lawyer, Professor Thomas Reed Powell of Harvard Law School, that 'while an expert can report what a court has said and

done, and can weave it all into an apparently neat and harmonious pattern, it still remains true that its often a gamble to try to forecast what the court will say and do next.'" He quotes Mr. Justice Holmes, "The life of the law has not been logic; it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious, even the prejudices which judges share with their fellowmen, have had a good deal more to do than the syllogism in determining the rules by which men should be governed."

Marriage and procreation are fundamental to the existence and the survival of the race. The power to sterilize can have far reaching, even destructive effects. Significantly, in this particular area, both the patient and the physician are puppets of the state rather than human beings capable of making adequate decisions. Birnbaum poses the question: "Is it morally just to eugenically sterilize a person without offering adequate treatment and rehabilitation?" He points out the age old question that has plagued man; that our society undoubtedly recognizes a moral right to treatment, but our courts and legislatures have never decided whether there is a legal right to treatment.

B. I. Kahn, M.D.

PHYSICAL ACTIVITY AND HUMAN ACTIVITY.

A. M. Chirico, M.D., and A. J. Stunkard, M.D., *New Eng. J. Med.*, 263:935-940, 1960.

This study, which is a combined effort of the departments of medicine and psychiatry, compared physical activity, as measured by a mechanical pedometer in non-obese men and women, with that of a group of individuals whose median figure for overweight is over 50%. Emotional attitudes towards activity were assessed by a questionnaire, and analyzed for a variety of responses including dependency, boredom, and social interaction. The mean activity of the obese and non-obese women was 2.0 and 4.9 miles per day, respectively. The difference was not as significant in the group of men, the obese men scoring 3.7 as compared to the corrected mean of 4.5 miles per day for the non-obese.

A study of the patient's self-estimate of activity on a full point scale ranging from overly active, to very inactive, revealed little difference between the estimate of activity made by obese women (who were actually less active) than that of non-obese women. However, more obese individuals expressed a preference for sedentary activities, such as watching television for more than 15 hours a week. There was no difference in the self-estimate of the "amount of food eaten when busy" in either group.

Whereas obese women responded to depression by passive acceptance, ("When I am blue, I sit" or "When I am down in the dumps, I am sad"), non-obese women frequently made responses indicative of a desire to struggle against the feeling of despondency ("When I am blue, I go out," or "When I am down in the dumps, I sing"). Obese women also revealed more social inhibitory responses than the non-obese women. Typical responses for the obese were "Working with people makes me feel bad—the others in the office make me feel slighted" as compared to those of the non-obese: "Working with people makes me feel just wonderful—others in the office make me feel good." In contrast, both obese and non-obese men responded in a passive manner to depression. Although obese men expressed little desire for social relations, they seemed to have as great a capacity for social interaction as non-obese men.

Physical inactivity, as measured by the pedometer, is characteristic of obese persons. However, physical activity is better estimated as caloric expenditure, by calculating a "coefficient of activity," namely: Distance walked \times (per cent overweight + 100). Although the calculated coefficient of activity for obese women was significantly lower than for non-obese women, this difference was not apparent in the male subjects. The sex dependence of the physical and emotional factors studied is important in regard to treatment of obesity. Since physical inactivity appears to play a greater etiological role in obesity in women, even small increases in activity might favorably alter caloric balance, and should be more productive of weight loss than in men.

Milton Gross, Ph.D.

REPORT ON THE RELATION BETWEEN MEDICINE AND PSYCHOLOGY. Bull. N. Y. St. District Branch, Dec. 1960, p. 6.

This article continues the report of the 1960 A.M.A. committee to study the relationships of medicine with allied health professions.

The following questions were raised: 1) Should medicine oppose any form of licensure of clinical psychologists, 2) Should clinical psychologists function in a medical setting with medical supervision?

Dr. Felix stated that psychotherapy is a form of medical practice and should be performed by physicians.

The American Psychological Association stands firmly upon the principle that voluntary self-regulation is not enough. They feel that mandatory certification is necessary.

The following are excerpts from other doctors' opinions: "Anyone who does psychotherapy on an unsupervised basis must be qualified pro-

fessionally to assume responsibility for the total care . . . (both organic and emotional concomitants) of the patient. This is primarily a medical problem."

"I see no method of arriving at a solution. I have always felt that we physicians in psychiatry have brought this on ourselves. In our hospitals, we have trained psychologists to conduct psychotherapy. It concerns me very much, indeed, that psychologists in private practice undertake the medical treatment of patients. They do not speak of this as medical treatment but as re-education and declare they are not practicing medicine. During intensive psychotherapy patients may well develop illnesses which psychologists are not trained to recognize."

Dr. Felix declared: "I would urge that the A.M.A. and state and local constituents make it a special project to bring to the physicians within their jurisdictions adequate knowledge of emotional illnesses and their treatment so that the great bulk of these can be handled by the doctor who takes care of the rest of the sick person. It is also important that he recognize at the same time that there are serious and complicated types of illness which only the specialist can treat."

Joseph Joel Friedman, M.D.

HYPNOTHERAPY IN HABIT DISORDERS. Herbert Mann, M.D., Am. J. Clin. Hypnosis, 3:123, January 1961.

Symptom removal by hypnosis need not be followed by a more harmful symptom. Wolberg is quoted: "No symptom will be abandoned which serves as a defense against intense anxiety." Hypnotic techniques can be applied advantageously in the treatment of habit disorders after the usual history-taking, physical examination, and indicated laboratory procedures. The successful hypnotherapist establishes rapport with his patient, which is often therapeutic in itself. Therapy is predicated upon acceptance of the patient's behavior without criticism, scorn, or ridicule. The physician must be confident in his ability to cope with the problem and have faith in the validity of the therapeutic technique he utilizes.

In analyzing therapeutic failures, it is apparent that the doctor's over-enthusiasm is a prime factor. Experienced hypnotherapists attempt to minimize the disabling aspects of their patients' symptoms, and yet permit neurotic needs to be served. More frequently used than symptom removal are symptom substitution, symptom amelioration, symptom utilization, or symptom transformation. Increased confidence of the patient in his ability to cope with his problem may then affect his total personality. It will restore his

self-respect and influence his capacity to deal with his symptoms, anxieties, and conflicts.

Leo Wollman, M.D.

PATTERNS OF SEXUAL BEHAVIOR FOLLOWING BRAIN INJURY. Edwin A. Weinstein and Robert L. Kahn, *Psychiatry*, 24:69-78, Feb. 1961.

This article reports on the findings in 36 patients, 17 men and 19 women who had demonstrable brain injury. The object of this paper is to describe the sexual behavior that was found in these cases, chosen from a total of 196 patients, 103 men and 93 women. Of this number, 21 patients, 10 men and 11 women, made sexual advances. Twelve patients showed exposure and masturbation, 20 showed delusions and confabulations with a sexual content. The authors concluded that the principal generalizations about premorbid behavior are the classification of the environment in sexual terms, the "emotional" quality of personal relationships, and the emphasis on "physical" symbols and show of feelings. Most of the patients were closely involved with the parents, especially the mother. Changes in the sexual behavior were also accompanied by other types of altered interaction with the environment, such as disorientation, reduplication, paraphasia, and mood changes.

James L. McCartney, M.D.

ON THE PARENTERAL USE OF AMITRIPTYLINE (ELAVIL): A PRELIMINARY REPORT.

H. Freed, *Am. J. of Psychiat.*, 117:455, Nov. 1960.

Amitriptyline (Elavil) is a dibenzl compound similar in structure and in pharmacological action to imipramine (Tofranil). Its use as an antidepressant has been reported in preliminary studies.

The author reported on the parenteral use of this drug on 23 patients. He found the intravenous use of amitriptyline to be safe within the range of 10-15 mg. and free from toxic symptoms. Drowsiness would occur when the intravenous dosage was 25-30 mg. The injection could be given twice daily in addition to oral medication. The intravenous medication was used to hasten the sedative and antidepressant effects. The author later placed the patients on an oral dose. He described marked improvement in two elderly patients with depression, anorexia and anxiety. Due to several "cerebral insults," neurological findings were evident. After treatment with amitriptyline, the mental and physical symptoms were greatly reduced.

In spite of the shortcomings of this paper as a scientific document, this report is significant as a preliminary study and should be followed by a well-controlled double-blind experiment. The

weakness of drugs like Elavil and Tofranil, as antidepressants, is the length of time it takes to relieve depression. If the intravenous use of these drugs should hasten prompt recovery, the result would revolutionize the therapy of depression.

Theodore Rothman, M.D.

THE PLACEBO. Pfizer Spectrum, Vol. 8 and 9, pages 208-209, December 1960.

Any objective contribution to the mystery of the placebo makes interesting reading. The placebo is defined as a substance that is administered, or a procedure that is undertaken which has no specific action.

There is no escape from the placebo effect of the physician himself, what with his opinions and his hopes. The history of medicine is replete with non-specifics from the early medicine man through Hippocrates to current medical practice. Therefore much of medicine, including that of today, is still a psychotherapeutic attempt to impress the patient.

According to this article, the placebo effect is real, measurable, but unpredictable. In a grem-lin fashion, it is known to foul up the double-blind technique, to induce physiologic changes, to produce "streptomycin toxicity" and anaphylaxis, and to relieve post-operative and cancer pain. The relief it promotes is proportionate to the degree of anxiety present. Oftentimes it is as equally active as an analgesic, and a switch from the placebo to the true analgesic will not always confer added benefit. Patients who profit from the placebo vary in response. Hotly debated is the advisability of placebo use. Psychiatrists generally oppose it as a substitute for psychotherapy.

The reality of the placebo is established. Used prudently, the paper concludes, it may be of value in treatment.

George J. Train, M.D.

COMBINATION DRUG THERAPY IN PSYCHIATRY. Joseph A. Barsa, M.D., *Am. J. Psychiat.*, 117:5:448, Nov. 1960.

Barsa points out that psychotropic drugs do not treat mental disorders, but rather, mental symptoms. The neurotic whose anxieties have been dissipated with tranquilizers will still retain his neurotic personality structure; the schizophrenic whose delusions and hallucinations have disappeared through the influence of drugs remains schizophrenic in character structure; the involuntal whose depression has been lifted with anti-depressants still has the unhealthy attitudes which permitted the depression to develop. Furthermore, the individual patient, neurotic or

psychotic, usually presents a multiplicity of symptoms which may call for a combination of drugs in his treatment.

Since patients' reactions to various drugs vary, the doctor should use combinations of drugs based on the patient's needs, rather than on the fixed proportion designed by the manufacturer.

Laurence Weiss, M.D.

PROJECTIVE TEST EVALUATION OF CHANGES EFFECTED BY GROUP PSYCHOTHERAPY.

Helene Papanek, M.D., *Inter. J. Group Psychother.*, 10:446-456, October 1960.

This is a before-and-after study of seven patients treated by group psychotherapy for ten months. None had any previous treatment. The group was heterogeneous with respect to diagnostic categories, educational background, and sex. All members received a battery of psychological tests including Rorschach, TAT, Figure Drawing, and Word Association, at the beginning and end of this period. At each session verbatim protocols were taken by a stenographer.

Changes in each patient are described in detail. These include diminution of anxiety, increase in self-esteem, less intense feelings of helplessness, especially toward authority figures, better ability to test reality and to relate to others, and decreased autistic and paranoid ideation, i.e., generally improved ego strength. A positive correlation was found between the test results and the protocols.

The author concludes that different patients use the group in different ways, according to their individual needs. Group therapy offers a situation with alternating security and challenge, graded anxiety, and opportunities for varied interpersonal relationships.

Elizabeth Thoma, Ph.D.

DISCIPLINING CHILDREN. A. H. Chapman, M.D., *G.P.*, 22/5:82, Nov. 1960.

Medical opinion is frequently sought by a parent when a child becomes a disciplinary problem. The effects of good or bad advice may be quite extensive since families tend to repeat their patterns of handling these problems from one generation to the next. In a sense, civilized society is possible only because adults enforce upon themselves the discipline others enforced upon them when they were small. Wise counsel by a physician may prevent serious difficulties later. Discipline and limitations can achieve healthy effects if they are imposed against the background of reasonable love and esteem of the parents toward the child. Dr. Chapman puts these principles into simple rules which he calls the three L's—love, limitations and let them grow up.

Parents should never threaten children with loss of love, abandonment or physical mutilation, they should never deprecate the child as an individual. Principles of discipline, desirable techniques, and the importance of the limitations are very well discussed.

Bertram B. Moss, M.D.

GROUP COUNSELING IN PRIVATE OBSTETRIC PRACTICE. N. Hurvitz, M.S.W., Ph.D., and R. P. Berko, M.D., *Obstetrics and Gynecology*, 16: 6, Dec. 1960.

This is a report of group counseling with a total of 30 expectant mothers. This was not preparation for childbirth and not group psychotherapy per se. It was conducted by two leaders, a physician and a family counselor. There was no planned discussion and the patients were encouraged to bring up whatever they wished. The discussion usually touched on several areas—attitudes toward pregnancy and motherhood, mood changes, fears, husband attitudes, the mother's social role, and psychosexual problems. These discussions resulted in better education of the mother, and an increased understanding of the attitudes, emotions, and tensions centered on pregnancy, motherhood, and the sexual role.

F. W. Goodrich, Jr., M.D.

NEUROLOGIC COMPLICATIONS OF CARDIAC SURGERY. A. Silverstein and H. P. Krieger, *Arch. of Neurology*, 3:601 (Nov.) 1960.

Nervous system involvement occurred post-operatively in 15 of 55 patients who experienced cardiac surgery. The complications included 1) embolic phenomena (2 patients with mitral stenosis), 2) Anoxic complications (convulsions, disturbances of consciousness), which occurred in 6 patients with a variety of cardiac lesions, 3) Mechanical complications (Horner's Syndrome and left recurrent laryngeal nerve paralysis) in 3 patients with coarctation of the aorta and patent ductus arteriosus, and 4) positional complications (left bronchial plexus involvement) in 3 patients. The authors note that only 6 of the 15 complications were initially recognized by the surgeons and cardiologists responsible for the post-operative care of the patient.

NON-INFECTIOUS GRANULOMATOUS ANGIITIS WITH A PREDISPOSITION FOR THE NERVOUS SYSTEM. H. Cravioto and I. Feigin, *Neurology*, 9:599-609, 1959.

The cerebral vessels may be affected in polyarteritis nodosa. Major intracranial vessels may be involved, but more frequently it strikes the smaller blood vessels of the meninges and parenchyma. The lumen is narrowed producing

ischemia. The symptoms are those of diffuse involvement of the central nervous system, and usually occur in the middle-aged. Convulsive seizures, paralyses, somnolence, sensory defects and aphasia are most frequent. The cerebrospinal fluid reveals a lymphocytic pleocytosis and sometimes xanthochromia.

TEMPORARY CARDIAC ARREST INDUCED UNDER HYPNOSIS. B. B. Raginsky, M.D., *Int. J. Clin. Exp. Hypnosis*, 7:2:53-68, 1959.

In a patient with Stokes-Adams syndrome, with frequent attacks of fainting over a period of six years, carotid sinus stimulation produced cardiac arrest. Bilateral neurectomy produced good results for 18 months. Sinus stimulations did not produce cardiac effects, as confirmed by the ECG. It was then decided to try a hypnotic experiment, under ECG control. Under deep hypnosis the former attacks could be reproduced when the patient was reminded of his earlier experiences and were removable by hypnotic suggestion. The author comments that in spite of the fact that the carotid sinus had been rendered insensitive by neurectomy, a purely mental process could bring back the attacks.

MAGNESIUM — DEFICIENCY TETANY SYNDROME IN MAN. B. L. Vallee, M.D., et al., *New Engl. J. of Med.*, 262:155-161 (Jan. 28, 1960).

This syndrome is virtually identical with that of hypocalcemic tetany, from which it can be differentiated only by chemical means.

In five patients studied, sustained losses of gastro-intestinal secretions, prolonged parenteral fluid therapy or severe infection acted as conditioning factors to produce the syndrome in previously malnourished persons. Tetany, with carpopedal spasm, Chvostek and Trousseau signs, athetoid movements, and convulsions were clinically observed in the presence of a normal level of serum calcium and a lowering of magnesium. In all five patients, parenteral administration of magnesium sulfate reversed the process.

AN INVESTIGATION INTO THE PART PLAYED BY ORGANIC FACTORS IN CHILDHOOD SCHIZOPHRENIA. D. Vorster, *J. Ment. Sci.*, 106/443:494-522, 1960.

The author points up that the increased incidence of prenatal, paranatal and postnatal trauma does not necessarily indicate brain damage. Emotional factors in the mother (during pregnancy) may so alter maternal biochemistry that it results in a larger number of traumata to the fetus. Similarly, the increased incidence of

postnatal vulnerability to infection, etc. may be a secondary phenomenon in which the primary one is the emotionally deprived child. Neurotic and psychopathic children may have as equally disturbed backgrounds as psychotic ones.

It is concluded that organic factors may play an important role in laying the ground for childhood schizophrenia, yet this ego-deficiency may fail to appear if the emotional atmosphere is supportive.

HYPOPHYSAL TUMORS. Deckers and Lauter, *Deutsch. Med. Wschr.*, 85/12:468, 1960.

In a study of 124 patients, the results obtained with operation or irradiation were good in about 50 per cent of the patients. All patients in whom visual power is reduced, or in whom there is a danger of blindness, should have surgery and no radiation therapy. In patients with chromophobe adenomas and those with acromegaly (without visual impairment), irradiation is the first choice.

PREDNISONE IN THE RELIEF OF ACROPAESTHESIAE. F. Lees and L. A. Liversedge, *Lancet*, 11/7112:1120-1122, 1959.

Prednisone was originally used in patients where acroparesthesiae were concomitant with definite arthropathy. This finding prompted its use in patients without demonstrable joint involvement. The authors feel that their results warrant their contention that the most important factor in the production of acroparesthesiae is the increase in volume in the contents of the carpal tunnel. They used the drug in a 5 mg. dosage 3 to 4 times daily.

EATING PATTERNS AND OBESITY. A. J. Stunkard, M.D., *Psych. Quarterly*, 33/2:284, 1959.

The author describes three distinctive eating patterns in obese patients: 1) night-eating syndrome, 2) binge eating, and 3) eating without saturation. In patients with the night eating syndrome, there is a characteristic insomnia and early morning anorexia. Binge eaters consume large quantities of food at irregular intervals. Patients with central nervous system disturbances may show difficulties in stopping their intake of food. In this latter group there is no apparent stress relationship.

MENINGITIS FOLLOWING TRAUMA TO THE HEAD AND FACE. E. Applebaum, M.D., *J.A.M.A.*, 173/16:1818-1822, August 20, 1960.

A total of 91 cases of post-traumatic meningitis were analyzed by the author. The interval between the trauma and the development of

meningitis ranged from several hours to five years. There were 15 instances of rhinorrhea or otorrhea and 13 cases with bleeding from the nose or ears. In 47 cases the etiological agent proved to be the pneumococcus.

Varying degrees of deafness occurred in five patients. One developed unilateral optic atrophy. There was one instance of a complicating subdural hematoma. There were two instances of brain abscess, both of which preceded the onset of meningitis.

The author points up that trauma to the frontal area, which contains the nasal sinuses, is particularly dangerous, since the dura is easily stripped from the bone, resulting in fistulous communications and allowing entrance of bacteria from the nasal passages.

A fracture that occurs across a chronically infected mastoid, associated with an inflamed dura, may lead to meningitis even in the absence of a dural tear. This was noted in one half of the cases.

The limitations of radiology in demonstrating basal fractures of the skull is emphasized. In 7 of 16 patients a fractured skull was found at operation or autopsy in spite of normal roentgenograms.

If recurrent meningeal episodes occur because of persistent or recurrent cerebrospinal rhinorrhea, it is necessary to close the fistulous dural communication by means of fascia lata transplants.

ACCIDENTAL INGESTION AND OVERDOSAGE INVOLVING PSYCHOPHARMACOLOGIC DRUGS. Howard W. Cann, M.D., and Henry L. Verhulst, M.S., *New Engl. J. of Med.*, 203/415: 719-724, Oct. 13, 1960.

This report from the Public Health Service indicates that of 280 reported cases, phenothiazines were involved in 89 of them; that children under 5 years of age accounted for 163 cases (62%). In 62% of the adults reported, meprobamate was the etiological agent.

As for suggested treatment, gastric lavage was attempted, even after manifestations of overdosage were present. Symptomatic treatment directed toward CNS depression and hypotension included intravenous fluids and electrolytes, vasopressor drugs, oxygen and artificial respiration. Caffeine sodium benzoate was used most frequently for mild CNS depression. Methylphenidate, amphetamine, nikethamide and pentylene-tetrazol were also used. Convulsions and extrapyramidal symptoms were treated with barbiturates; diphenylhydantoin was used in one case of convulsions and atropine in one patient with extrapyramidal symptoms.

When extrapyramidal symptoms are encoun-

tered, a mis-diagnosis of encephalitis, meningitis, tetanus or poliomyelitis may be made. Large amounts of meprobamate may produce sedation, drowsiness, ataxia and coma.

With the phenothiazine derivatives, due to their anti-emetic action, attempts to induce emesis may be unsuccessful. The treatment of phenothiazine-induced hypotension with epinephrine is useless, if not dangerous, because its pressor action is reversed by the drug. Nor-epinephrine should be used. Phenothiazine-induced extrapyramidal symptoms may respond to I.V. caffeine.

Patients with severe CNS depression following meprobamate, who fail to respond, in whom urinary output is poor, may respond to extracorporeal hemodialysis. Children may respond to exchange transfusion. The use of the latter in children with serious chlorpromazine poisoning has also been suggested.

CLINICAL APPLICATION OF FLUID AND ELECTROLYTE BALANCE. *Physician's Bulletin*, Eli Lilly & Co., Vol. 26, No. 1, Feb. 1961.

The renal excretion of water and sodium is decreased in situations of tension and discouragement. Increased excretion of sodium was associated with anger, excitement or apprehension. It thus seems possible that emotional factors can precipitate cardiac decompensation and that the doctor's reassurance may be a significant factor in the management of congestive heart failure.

A decrease in blood potassium may produce mental cloudiness and infusion of potassium can reverse the mental picture.

The oliguria and hyponatremia after trauma is due mainly to the secretion of the antidiuretic hormone. It can also be produced by fear and pain. Oliguria, since it retains water, produces a "dilutional hypotonicity." Hyponatremia is also seen in debilitating disease. States of edema can be accompanied by low serum sodium concentration due to dilution hyponatremia. Apathy and anorexia are characteristic signs.

Hyponatremia may be evidenced by cerebral disturbances, inclusive of hallucinations and delirium.

AN APPRAISAL OF PSYCHIATRY IN GENERAL PRACTICE. L. M. Franklin, M.R.C.S., D.P.H., *Brit. Med. J.*, Aug. 6, 1960.

Psychotherapy as a specific therapy is more effective for some psychiatric disorders than for others. The condition which responds best is an anxiety state in a young adult.

Psychotherapy may be ineffective and so lead to discouragement of both doctor and patient; in other cases it may actually be harmful. It is most important that a diagnosis be established

before starting therapy, lest harm be done by inappropriate treatment.

Five main groups are encountered in general practice. 1) Anxiety states—these either respond quickly or scarcely benefit at all. 2) Psychosomatic states—these are often helped by psychotherapy, but often a great deal of work seems to produce little reward. 3) Depression—this can be made worse by psychotherapy of any depth. Psychotherapy here should amount to little more than a sympathetic ear and an understanding manner. 4) Schizophrenia—This is virtually uninfluenced by psychotherapy in the opinion of the author; in any case it is difficult to establish a normal relationship with an active schizophrenic. 5) Hysteria—Psychotherapy is difficult and is best restricted to a discussion of the patient's current problems.

(Editor's Note: It should be noted that the author's appraisal relates to the efforts of the generalist. No mention is made as to the qualifications and training of the individual practitioner—which must of necessity vary in each individual instance.)

CHEILITIS GRANULOMATOSA AND MELKERSSON-ROSENTHAL SYNDROME. C. W. Laymon, Arch. Derm., Vol. 83, Jan. 1961.

In the Melkersson-Rosenthal Syndrome, there is a chronic enlargement of the lips, facial paralysis, and scrotal tongue. The author states that there is insufficient evidence to link cheilitis granulomatosa with sarcoidosis. Leukoplakia is rare. Various forms of treatment have been unsuccessful.

POSSIBILITY OF IATROGENIC FACTORS RESPONSIBLE FOR HYPERNATREMIA IN DEHYDRATED INFANTS. V. R. DeYoung, M.D., and E. F. Diamond, M.D., J.A.M.A., 173/16: 1806-1808, Aug. 20, 1960.

In 47 patients under four years of age who were admitted to the hospital because of acute diarrheal disease, 10 showed hypernatremia, with sodium concentration of 150 mEq. per liter or greater. Six of these patients had convulsions and in nine there was coma of varying duration. In three instances, the infants were only moderately ill on admission but become seriously ill and showed central nervous system signs after the administration of salt-containing fluids in dosages larger than those usually recommended.

The ingestion of whole milk without supplemental water throughout the period of diar-

rhea will result in a hypertonic dehydration. Isotonic sodium chloride by hypodermoclysis supplies 154 mEq. of sodium chloride per liter, which may attract water and electrolytes from the extracellular fluid. Rapid administration of fluid to a lethargic, dehydrated infant may be dangerous.

The most commonly reported lesions at autopsy were subdural effusions and meningeal hemorrhages. The bleeding may be the result of the tearing of the bridging veins as water leaves the cells rapidly and engorges the perivascular space.

In three instances convulsive disorders persisted after recovery from the hypernatremia.

ELECTROENCEPHALOGRAPHIC ABNORMALITIES AND PSYCHIATRIC MANIFESTATIONS IN INTERMITTENT PORPHYRIA. Z. S. Sikes, M.D., Dis. of the Nerv. System, 21/4:226-229, April 1960.

An episode of porphyria may begin with abdominal pain, neurologic or mental symptoms. It is often accompanied by the passage of dark or maroon colored urine. Two cases are reported in which abnormalities were found in the electroencephalogram.

The psychiatric symptoms are compared with those seen in experimental psychoses produced by lysergic acid diethylamide (LSD) and mescaline. The author feels that the syndrome of porphyria is central in origin due to effects on the mesodiencephalic activating system.

PROXIMAL OCCLUSION OF THE ANTERIOR CEREBRAL ARTERY. J. E. Webster, M.D., et al., Arch. Neurol., 2:19-26, Jan. 1960.

Occlusion of the anterior cerebral artery is associated with neurologic and psychiatric symptoms. Among the former is weakness of the contralateral half of the body, especially in the upper extremity. Among the latter are included dementia, anxiety and loss of initiative. Non-filling or thread-like filling in angiographic studies may be due to occlusive atherosclerosis or congenital anomalies. As an aid to diagnosis, contralateral digital carotid artery compression may be used during the angiographic study. This will frequently result in syncope associated with grasping movements of the upper extremities. A positive carotid artery compression test may help to differentiate functional disease, particularly in patients over the age of 40.

W.D.

Book Reviews

PASSPORT TO PARADISE . . . ? By Bernard Finch. New York: Philosophical Library, Inc., 1960. Pgs. 191. \$6.00.

This book should be of great interest to the general reader. To those with especial predilection for matters medical, "Passport to Paradise . . . ?" could well serve as "The Layman's Guide to Pharmacology and Pharmaceuticals." There is an extra hidden bonus or kicker, as the name implies, in the emphasis placed on drugs affecting behavior, moods and emotions. Addiction is played up, with commendable restraint however, and all the illustrations (16) are devoted to some of its aspects. The occasional moralistic tone that creeps into the well-written text is unobjectionable, and the avoidance of sensationalism does not detract from the sustained interest in the fascinating subject matter.

For the medical man, the book serves as a rapid review of drugs, their origins, interrelations and actions. It clothes many of the bone-dry facts, some of which may have long since crumbled into oblivion, with a life-like vividness. It may even bring a nostalgic recall of "the memory of things past," a re-acquaintance with early pharmacologic friends and at least a passing nod to the more absorbingly interesting ones of the present.

Sam Silber, M.D.

PROGRESS IN NEUROLOGY AND PSYCHIATRY—AN ANNUAL REVIEW, VOL. XV. Edited by E. A. Spiegel, M.D. New York: Grune and Stratton, 1960. 619 pages. \$12.75.

This encyclopedic review of 1960, which covers over four thousand contributions, includes every phase of the field. It is divided into four parts: basic sciences, neurology, neurosurgery and psychiatry. These are further subdivided into distinct specialty areas, each edited by its own experts.

The subdivisions include neuroanatomy, neurophysiology, neuropathology, clinical neurology, neuroendocrine relationships, electroencephalography, radiology of the skull, peripheral nerve and spinal cord surgery, brain tumors, the cerebro-vascular system, psychosurgery, clinical psychiatry, psychosomatic medicine, psychoanalysis, drug therapy—and many others.

Some of these sections will be of especial interest to the readers of *Psychosomatics*. There are many pearls scattered throughout its pages. A few of the highlights to this reviewer include: the studies on lipid metabolism in multiple sclerosis with the possibility of the use of heparin (pg. 149); the fact that hyoscine is the best drug

for motion sickness (pg. 172); the role of the EEG in diagnosing carotid artery occlusion (pg. 256); the entire chapter on radiology (pg. 307-321); the surgical correction of tardy radial and ulnar nerve palsy (pg. 326) the fact that dysphagia can be produced by hypertrophic spurring of the cervical vertebrae and may be amenable to surgery (pg. 331); that backache may be due to vascular insufficiency of the lower aorta or common iliac arteries (pg. 332); the occurrence of papilledema in hypothyroidism (pg. 358); the differences in the attitude of the British and the American neurosurgeons to the potential value of lobotomy (pg. 389); the studies which indicate that leukotomy is particularly valuable in depressive states where there is marked obsessional preoccupation (pg. 388); the fact that the advent of the new drugs has produced an increasing awareness in non-psychiatrists of their need for increased knowledge in psychophysiology and psychopathology.

Of particular interest is the chapter on Psychosomatic Medicine, edited by H. Keith Fischer, M.D. (pg. 462-471). Although this is short and far from comprehensive, reference is made to the Transactions of the Academy's meeting in 1958 titled "The Psychosomatic Aspects of Internal Medicine" (pg. 468).

In the chapter on "Psychoanalysis," a report of one analyst is cited: "With every one of my patients (schizophrenics) who has progressed, I have experienced romantic and erotic desires of being married to the patient" (pg. 474). The author stresses the importance of resolution of this counter-transference, and with this concept this reviewer would readily agree.

In a review of how candidates for psychoanalytic training are selected, it is shown that the "core of psychoanalytic aptitude in the male resides in his psychologically accessible latent femininity and his correlated passivity. This attribute will apparently permit him to wait and listen—something to which an 'aggressive masculine tendency' cannot be subordinated." The editor of the chapter points up that Ernest Jones, (the biographer of Freud), would probably not have been accepted (pg. 489). This reviewer feels that this finding, if true, should be repressed, suppressed or rationalized by psychoanalytic institutes. It may make physicians who have not as yet become accessible through personal analysis, hesitant about accepting it as their life's work. One wonders which particular culture still provides "listening females"—but caution and tact suggest that this item should be left unchallenged.

The chapter on "Drug Therapy" is particularly

valuable (pg. 540-576); most of the present day drugs are evaluated critically. Most important is the reminder that besides evaluating the drug, one must evaluate the attitude of the physician who uses them as well as the setting in which the particular patient is treated.

This book is most heartily recommended. It is highly readable, interspersed with the editor's comments in each section. The bibliography is extensive. It most assuredly will meet the needs of all physicians interested in recent progress.

W.D.

EROTIC SYMBOLISM. By Edward Podolsky, M.D. and Carlson Wade. (Epic Publishing Co., Inc., 1960). \$7.00.

It is difficult for the reviewer to classify this book as one published strictly for members of the medical profession, psychoanalysts and students in the field of psychological or social studies, as is stated on its picturesque covering, which could easily remind one of the sensationalism of the former *Police Gazette*.

The book represents material engaged in a study of fetishism in relation to sex, enumerating common fetishes such as corsets, high heels, hair, gloves, high boots, silk stockings, laced shoes and costume jewelry, all of which have been well known to the psychiatrist. A sixteen page pictorial review of models wearing these items are shown to reveal the erotic symbolism that they possess.

The author states that the fetishist has no sexual aim toward an individual of the opposite sex and uses a fetishistic object for his sexual gratification during his entire sexual life. The fetishistic object may be articles of clothing, shoes, stockings, furs, underclothing or parts of a human body. The object may, therefore, be animate or inanimate. Dr. Podolsky goes on to classify body parts by costuming. Shoe fetishism has been called *retifism* (after *Retif de la Bretonne*) who was a shoe fetishist. *Frotteurs* who rub up against women in crowds are *buttock fetishists* and *epilateurs* are actually hair fetishists. Coherent or tactile fetishists are those who put some object in contact with their body. Acoustic fetishism is the satisfaction obtained by listening to smutty stories.

The fetish represents to the fetishist one of the sexual organs such as the penis, vagina or the womb. Fetishists prefer self-gratification with or by means of a fetish rather than normal sexual relations. Fetishism assures chastity to the fetish lover. The fetishist may be passive or actively aggressive but in both instances sadistic. Some have criminal tendencies leading to assault, mutilation and murder.

Dr. Podolsky then reviews the opinions of Karl

Abraham, Sandor Rado and Otto Fenichel in relation to transvestitism. This is rather odd in that the sexual aims of the transvestite often differ from that of the fetishist.

In summary, the fetish is an object endowed with sexual significance which enables the fetishist to discharge his sexual tensions. The fetishist may be harmless or dangerous according to his motivations and sexual drives.

The book is recommended to those who would require a quick review of the subject. It is written in lay language and lacks a bibliography.

Harry Perlowitz, M.D.

TREATMENT FOR NEURASTHENIA AND COMPULSIVE NEUROSIS (MORITA THERAPY). By Masame Morita, M.D., Tokyo, Hakuyo-Sha Co., 1956.

According to the Morita School, the anxiety of a neurotic person is caused by his specific reaction to his unfavorable environment. He feels his psychological as well as physiological reactions are special to him and abnormally different from those of others. In contrast, normal people usually show the same or similar reactions but never think or feel that they are of special or abnormal nature. This school enumerates several characteristics of the neurotic personality:

(1) The most outstanding characteristic is hypochondriasis. (2) Neurotic individuals attempt to make the impossible possible. A neurotic individual, for instance, complains about his difficulty in concentration and asks the doctor to clear out those miscellaneous ideas and images that prevent him from obtaining a perfect state of concentration. Other neurotics may complain that they cannot attain the absolute or the perfect. It is a matter of simple common sense to understand that this is impossible. (3) Neurotic individuals do not want to face anxiety directly. They try to evade, deny, rationalize, or escape from it. It is important to face it, accept it and suffer with it. (4) Neurotic individuals do not accept facts and learn from them. (5) Neurotic individuals tend to think of themselves as set apart, and different from others. (6) Neurotic individuals wish to have happiness without effort. (7) In contrast to an insistence on absolute perfection, it is a conspicuous fact that every neurotic individual is troubled by a feeling of inferiority or incapacity.

Morita and his followers consider first that learning in and through daily experience is more fundamental and deeper than intellectual understanding. Secondly, they prefer a direct approach to the stimulation and development of the constructive force within the patient, rather than the analytic approach to the obstructive, pathological aspects of the patient. The followers of

Morita are under the impression that if the constructive force is strengthened and mobilized freely and powerfully, the pathological aspects will fade away.

The following important factors which are utilized for the promotion of the constructive force must also be mentioned: First is the stress on the curative effects of nature; second, emphasis on manual work; and third is the importance of the attitude called "acceptance."

Dr. Morita advises the patient to take reality as it is, accept it and live with it without struggling to evade, escape, or deny it. Acceptance, although it is commonly misunderstood in Western cultures which emphasize activity, is not mere passivity or resignation. It is a realistic attitude consisting of a clear cognizance of the reality of a given situation and the courage to embrace and live with this reality. It is quite a positive attitude and can be called "creative passive-activity." Dr. Morita suggests that manual work should be carried out in whatever field the patient feels he likes. At first the patient is always concerned with symptoms, but as he becomes more involved in his work, he seldom pays attention to them, and through this experience in his work he begins to learn how to "accept."

Morita therapy has developed basically from the traditional ideas towards life and humanity which are essentially those of Zen Buddhism. Re-examination of the whole system in the light of psychoanalysis and a re-appreciation of Zen Buddhism can help this therapy develop more effectively and profoundly.

Yujiro Ikemi, M.D.

SLEEP THERAPY IN THE NEUROSES. B. V.

Andreev, M. D. New York: Consultants Bureau, 1960. 114 pages.

This small book is one in the International Behavioral Science Series, edited by Joseph Wortis, and for which he wrote the foreword. In it he states that Pavlov was convinced that sleep, hypnosis, and hysteria represented different types and degrees of inhibition, and came to regard certain morbid conditions in both animal and man as reflections of partial inhibitory states. He then goes on to point out that as a result of his work, Pavlov not only recommended an especially quiet, sheltered routine for such patients, but encouraged the reinforcement of this protective inhibition by the use of sleep.

The author goes into some length about the development of sleep therapy and points out that "In the assessment of the duration of therapeutic sleep we have employed the objective method of actography, recording the motor activity of the subject, which in most cases allows us accurately to record the transition from waking to

sleep and vice versa. By the use of this method we were able to make observations on the efficacy of various measures in prolonging sleep. We have improved the technique of actography and have adapted it to clinical practice. The main advantages of this method are that the motor activity is recorded automatically, without the intervention of the experimenter, continuously for 24 hours, and the subject's sleep is not disturbed."

In five chapters, Andrew discusses: "Modern Views on Neuroses," "A Brief Outline of the History of the Method of Sleep Therapy," "The Indications for Sleep Therapy in Neuroses," "The Investigation of Sleep by the Method of Actography," and "Sleep Therapy in the Neuroses." On page 64, he goes into some length on the use of hypnosis and suggestion, discussing both direct suggestion without medication, as well as the use of various drugs in the induction of sleep. Fortunately, on page 96 he points out that "Sleep therapy should not be regarded as a radical method which, if used alone, will completely cure a neurosis. It is rather a particular stage of treatment, to prepare the nervous system for receiving subsequent forms of therapy: training, active psychotherapy and so on; it is therefore important to use it as soon as possible in order to enhance the tone of the nerve cells."

As Wortis says in his concluding paragraph, "The book should serve not only to encourage the use of a valuable form of treatment, but should help to point up the importance of a type of clinical approach and analysis that can relieve and refine the raw empiricism upon which so much current psychiatric treatment is still forced to depend."

James L. McCartney, M.D.

FUNDAMENTALS OF NEUROLOGY. By Ernest Gardner, M.D. Philadelphia: W. B. Saunders Co., 3rd ed., 1959. 388 pages.

This book will meet the needs of post-graduate students. It is brief, precise and readable. The illustrations and photographs are plentiful, and well labeled. The twenty chapters are all short. Definitions are concise and easy to remember. Anatomic terminology is simplified by the use of the most recent revision of terminology (*Nomina Anatomica*), submitted by the International Anatomical Nomenclature Committee of the Sixth International Congress of Anatomists in Paris, 1955.

The last chapter dealing with the chemistry of the nervous system is all too brief for a rapidly growing subject which is important to neurology. Two paragraphs dealing with metabolism of the brain and peripheral nerves are worthy of quotation: "the brain contributes more

to the basal metabolic rate, relative to its proportion of body weight, than do most tissues and organs. Oxygen consumption is higher in gray matter than in white, and is higher in the brain than in the cord. Most nerve cells, especially those in the higher centers, cannot survive more than a few minutes' deprivation of oxygen."

Under carbohydrates: "To date, little is known about the way in which energy is used in the nervous system, but considerable information is at hand about the way in which it is made available." The degradation of glucose to carbon dioxide and water and the series of intermediate steps explaining how high energy phosphate groups combine with adenosine mono-, di-, and triphosphates liberating enormous amounts of energy in the mitochondria is simply diagrammed and explained. Under proteins a very brief reference is made to phenylpyruvic oligophrenia. "Apparently the enzyme that converts phenylalanine to tyrosine is missing. Why this block in phenylalanine metabolism leads to mental retardation is unknown, but it may be more than fortuitous that tyrosine is the precursor of the nerve impulse transmitters, adrenaline and nor-adrenaline." Under lipids, Tay-Sachs disease and Niemann-Pick disease are mentioned and dismissed with, "these and other lipid disorders are due to faulty functioning of some essential enzyme system." There appears this brief mention of serotonin: "Serotonin which causes smooth muscle to contract, has been found in considerable amounts in the brain. Recent studies suggest that it is concerned in maintaining normal mental function."

The basic importance and practical significance of biochemistry in neurology will certainly demand more than one chapter in future revisions of this book.

The glossary of new terms and the index are both good.

Joseph Joel Friedman, M.D.

CULTURE AND MENTAL HEALTH. Edited by Marvin K. Opler. New York: The Macmillan Co., 1959. 533 pages. \$8.75.

This is a study of the effects of different cultures on mental health. The contributors include representatives from varied disciplines: psychiatry, anthropology, sociology, psychology and public health.

In studies of the American Indian, the author questions the relatively low incidence of mental disease in so-called primitive peoples since the delusional system of an individual in such a society must be evaluated by the local standards.

In the Iroquois, it seems that the tribe was intimately acquainted with the phenomenon of reactive depression, in that the burial and mourn-

ing rites showed a real concern for the survivors. The departed Indian was thus surrounded by material goods that would be needed in the next world; the survivors first "suffered" through a ten-day feast, then went on the warpath. By bringing back prisoners who were subsequently eaten (incorporated), to replace the mourned-for dead one, they obviously showed an intuitive insight into the basic psychodynamics of depression.

Studies of people of the South Pacific show that each culture produces stresses and also provides techniques for their reduction and possible resolution. In Ifaluk, an atoll in Micronesia, the natives were characterized by an absence of aggression and competitiveness, yet were basically anxious. Just as the Sioux Indian's hostility has been traced to the strapping down of infants with subsequent inability to abreact rage, the anxiety in this group was traced to the established custom of an early morning bath in a cold lagoon.

Studies of the Japanese suggest that the tie between mother and son is not broken as completely as is true in the United States. (This differentiation may not be acceptable to many American therapists.) However, in Japan, the eldest son's wife is chosen by the parents, so that the marriage is more of a relationship between two families than two individuals. The wife lives with the mother-in-law and husband. In the inevitable arguments, the husband favors the mother. The author sagely comments that many strains come from the desires of young couples to establish separate family units.

In Japan, the Morita treatment is utilized as psychotherapy for neuroses. The patient is first isolated, then communicates with his doctor through a diary, and then is encouraged to engage in simple manual tasks. The emphasis is on the treatment of the patient "through his daily life experiences." (The Japanese evidently prefer this to psychoanalysis.)

Other studies include Chinese, Indian, and African cultures. Most interesting is the ritual known as the Nomkubulwana ceremony seen in the Zulus. Here the female temporarily assumes male behavior and dress and is permitted to indulge in obscene actions and lewd utterances. (This is supposedly good for the crops as well as for the psyche.) Strangely enough, this ceremony became less and less common with the beginning of the twentieth century and was replaced by a type of conversion hysteria, locally known as Ufufunyana, allegedly caused by witchcraft or spirit possession (an etiology which apparently has no cultural or geographical boundaries).

In studies of the Bantu, a high homicide and

a low suicide rate were correlated with the low incidence of depression. The low incidence of coronary disease in the Bantu is related entirely to "social environment" by the author. (The factors of heredity, low cholesterol diet and individual reaction to stress are considered to be quite secondary.)

Other studies include reports on the English "acceptance of eccentricity" (accounting for the lessened hospitalization of mental patients); studies of the mental hospital in the U.S.A.; problems of the Negro personality; cultural differences as an explanation for the difference in the clinical pictures of schizophrenia in the Italians and the Irish; and studies of personality adjustment among different generations of American Jews and non-Jews.

This book, with its wealth of material which deals with cultural influences in different areas of the globe, is a valuable contribution. The student of human behavior, no matter how he is labeled, will find much of interest within its pages.

W. D.

THE FIRST FIVE MINUTES. Robert E. Pittenger, M.D., Charles F. Hockett, Ph.D., John J. Danehy, M.D. Ithaca, New York: Paul Mar-tineau, 1960. 264 pages. \$6.50.

Like phonograph records of grand operas, tape-recordings of psychiatric interviews contain huge numbers of sounds, some of which reflect the deliberate and others the accidental actions of the drama. For some years now psychotherapists have diligently made tape-recordings of interviews, and in many clinics and teaching hospitals these have started to pile up alarmingly. One reason for this is that few therapists have developed methods for analyzing the sounds on the tape. The problem is this: in listening to words one deals with content, and this can be done more objectively with a typewritten transcript. On the other hand in working with the rhythms, inflections, snorts, and moans that get onto tape but not into a typed script, one has to deal with the subjective impressions which always accompany listening in the dark.

Several investigators have applied themselves to this problem, and one of the most interesting results in this modest book by Pittenger, Hockett and Danehy. They took the first five minutes of a recorded interview conducted by Dr. Merton Gill and converted each sound into a written symbol. Words were denoted with phonetic signs derived from standard linguistics, while nonverbal cues such as silences, getting-louder, increasing-tempo, register-shifts, and noises are denoted with paralinguistic signs developed by the authors and their associates. The transcription is accompanied by descriptive statements about

the sounds on the tape, plus interpretive comments about what was probably happening during the interview. The range of interpretations is refreshingly broad. Some deal with covert, physiologically-determined motives; for example, the patient's disinclination to speak and her desire to smoke at one point my represent "a wish for oral intake rather than oral output." Other interpretive comments are about the overt behavior of the psychiatrist in the presence of his patient; for instance, a slight increase in the rate of breathing on the part of the therapist may be part of his "machinery for signalling for kindness or—a failure to conceal completely his own affect" about the patient. What makes the descriptive material particularly enjoyable to read is the novelty and preciseness of the labels that Drs. Pittenger, Hockett, and Danehy have attached to certain sound-events, for example: "opaque intonation," "fracture," "fade-in," "topic-inertia," and "accuracy-compulsion." One eagerly wants to see how closely their interpretations correspond with what actually happened during "the first five minutes."

The science of human sounds being an embryonic one in today's behavioral research, the authors wisely restrict this book to a detailed presentation of data plus the exposition of their method and working hypotheses. The orientation is clinical, which makes this book appealing to practicing therapists and physicians. An additional advantage lies in its synthesizing many ideas about communication which come from non-medical fields like anthropology and linguistics.

One of the most profound statements in the book is that for each communicative act "at every available magnification, the revealed detail is culturally patterned." Anyone seriously interested in this question of the inter-relationship between instinctive and learned patterns of behavior will be richly rewarded by "The First Five Minutes." And for those who study concrete manifestations of this inter-relationship in the actual clinical interview, this book is a must.

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atry.

ENCYCLOPEDIA OF MEDICAL SYNDROMES.
Robert H. Durham, M.D. Paul B. Hoeber, Inc.,
N. Y., 1960. Pp. 628. \$13.50.

This encyclopedic compilation, which includes nearly 1000 medical syndromes, is most unusual. It is no mere collection of definitions, but a concise presentation of the essential clinical facts, replete with bibliographic references. The material is arranged alphabetically; there are cross references which include related syndromes.

Both eponymic as well as descriptive titles are used. The index is particularly valuable since it permits the reader to readily locate syndromes whose names so easily slip away from immediate recall.

Of particular interest to the reader of *Psychosomatics* is the original reference to Adie's syndrome (pg. 11), the "Alice in Wonderland" syndrome (pg. 19), the syndrome of crocodile tears (pg. 67), Capgras' syndrome of non-recognition-and-misidentification (illusion of seeing a double, pg. 83), Claude Bernard's syndrome, a reversed Horner's syndrome (pg. 111), the Ellenor syndrome (relating to a companion of Ulysses who had some unusual post-alcoholic experiences (pg. 169), the Running Fits syndrome (pg. 174), Garcin's syndrome of unilateral involvement of all cranial nerves (pg. 214), the Laughing Death syndrome (pg. 305), the Marchiafava-Bignami syndrome of corpus callosum generation due to "dago red wine" (pg. 339), and the "Women Who Fall" syndrome (pg. 606). This last one might also be named "Fallen Women" and is found to be related to a timid ego and the emergence of aggressive or erotic impulses (or both).

This book is not only refreshing medically, but makes for delightful reading. W.D.

MAN'S PRESUMPTUOUS BRAIN. By A. T. W. Simeons, M.D., New York: E. P. Dutton & Company, 1961. \$5.75.

Dr. Simeons, an Englishman, studied medicine at the University of Heidelberg, did post-graduate work in surgery in Germany and Switzerland, later went to India where he received the Red Cross Order of Merit for his research in tropical diseases. He is now working with psychosomatic disorders at the Salvator Mundi International Hospital in Rome. A physician with such a background may be presumed to have seen enough of disease, enough of the world, and enough of the impact of psyche on soma, to make his recorded observations worthy of attention. This volume, written ostensibly for the intelligent layman but, I suspect, hopefully also for the potential medical convert to the psychosomatic point of view, most certainly warrants perusal even by those sophisticated in psychosomatic theory.

Dr. Simeons' approach to his subject is evolutionary. Thus, a considerable portion of the volume, perhaps a little too much, is concerned with the evolution of the human body, the evolution of human psyche, and the spread of human culture. In a second section, he relates these developmental processes on all levels, with the genesis of psychosomatic disease. He integrates his science well.

The argument portrays man with a brain far too advanced for his body and with an overdeveloped censorship. He builds an artificial environment, making his animal reflexes nearly obsolete. Psychosomatic ailments are viewed as a conflict between this "presumptuous brain" and more animal-like body. Artificial defenses are created through a cultural elaboration of weaknesses. Man's civilization is thus an artifact and an artificial means of escape. He neglects his midbrain and manages intellectually to adjust the world to his body rather than follow the archaic biologic pattern of adaptation to environment. He lives, then, in fear of fear and in dread of disease, the antagonism between instinct and intellect creating a primeval panic. The ultimate conclusion when this conflict remains unresolved, according to the author, is psychosomatic suicide.

The clinical sections on disorders of the digestive tract, cardiovascular system, thyroid gland, bone and muscle, and sex, will be of interest to practitioners working in these fields. The author's rather fresh and novel restatement of the ego-id conflict may be provocative for anyone interested in the vagaries of human behavior.

Sanford M. Lewis, M.D.

CHRONIC SCHIZOPHRENIA. Edited by Lawrence Appleby, Jordan M. Scher and John Cumming. The Free Press of Glencoe, Illinois, 1960. 368 pages. \$6.00.

This book is an exploration into theory and treatment of chronic schizophrenia. It is an account of the proceedings of a conference held in October 1958 at Osawatomie State Hospital in Kansas, in which contributors from many disciplines participated.

The preface, by Dr. Karl Menninger, notes that "the psychology of schizophrenia is as much in the mind of the observer as in the mind of the patient"; that its victims have been considered incurable because of the doctor's feeling of hopelessness. The spirit of the conference is in keeping with these facts; that as psychiatric advances are made, doctors change their attitudes, replacing apathy with hopefulness.

In all, fifteen papers are presented. Although the conference does not solve the problem of what schizophrenia may be, nor does it provide a final answer as to how to cure it or prevent it, it does serve to break down communication barriers between the patients, doctors, and the members of the community in which they both live.

In a consideration of the treatment programs within hospitals, it was agreed that the importance of nurses and aides was inestimable. The need for delegating adequate authority to the nurse is pointed up as well as the obvious fact

that the "professional psychotherapist" can no longer be the only one who treats schizophrenics in an institution. Most interesting is the concept of "intrusion" into the tendency of the chronic patient to remain seclusive, inactive and unmotivated; also, in considering treatment, it is brought out that instead of trying to "cure" schizophrenics, one is now trying to resocialize them—a much more realistic goal.

W.D.

SIGHT. A Handbook for Laymen. Roy O. Scholz, M.D. New York: Doubleday and Company, 1960. 166 pages. \$3.50.

This book is wholeheartedly recommended to laymen as a source book of information. The author is an eminent ophthalmologist and the information dispensed appears impeccable. Dr. Scholz wrote the book to help answer the many intelligent questions his patients have asked. He designed the book to enable the patient, at his leisure, to gain a broad nontechnical view of the functioning of the eye both in health and disease. The book is not intended as an aid to diagnosis but simply as an aid to giving the layman a better understanding of the problems of vision. This book is written in a popular vein as witnessed by the following short paragraph:

"Over the front of the globe are the eyelids with their lashes, which act like an automatically operating windshield wiper. Their continual blinking keeps the front of the eye moist and cleared of dust particles. Undoubtedly you have noticed that when you are out in a high wind your eyelids blink faster than usual."

It goes into factual data regarding the eyes, but not too deeply, and it seems to cover most every facet of the problem. It does not emphasize psychosomatics.

T. F. Schlaegel, Jr., M.D.

DRUGS AND BEHAVIOR. Edited by Leonard Uhr and James G. Miller. New York: John Wiley & Sons, Inc., 1960. \$10.75.

The past decade has witnessed an unprecedented interest in drugs which affect the psyche and behavior. More than fifty thousand articles have been published on tranquilizers, antidepressants, and psychotomimetic agents. It is a rare medical meeting today that does not have on its program a paper on some aspect of neuropsychopharmacology or drug therapy for psychiatric disorders. In view of these facts it is surprising that so few books on drugs for the mind have appeared.

Drugs and Behavior is a compilation of articles by sixty-three authors among whom are some of the foremost experts on drug research, clinical and experimental. This book is devoted to an extensive review of the problems and techniques

of evaluating psychoactive drugs. For clarity, the editors have divided this tome into two portions. Part One deals with the chemical, biological, and clinical context of psychopharmacology. This section contains some excellent articles, especially Kurland's review of "Placebo Effect" and Freyhan's thoughtful commentary entitled "Psychopharmacology and the Controversial Clinician." Part Two covers experimental procedures and results. The majority of the chapters in this section report experimental results with a variety of drugs which clinicians and experimentalists will find interesting and informative.

Despite the multiple authors and the diverse topics covered, the editors have succeeded in minimizing redundancy and unifying the subject matter. This is a book for students of neuropsychopharmacology and experts in drug evaluation. Each chapter merits special, careful perusal. There is a wealth of information here which can be extracted only by attentive study. This is not a volume for casual reading.

Frank J. Ayd, Jr., M.D.

REHABILITATION OF THE MENTALLY ILL. SOCIAL AND ECONOMIC ASPECTS. Edited by Milton Greenblatt and Benjamin Simon. Washington, D.C. Amer. Assoc. for the Adv. of Science, 1959. 250 pages. \$5.00.

This book is a symposium co-sponsored by the American Psychiatric Association, the American Association for the Advancement of Science, and the American Sociological Society. It reflects a marked increase in interest in the rehabilitation of the mentally ill. Behind this interest lies the work of the Veterans Administration hospitals, liberal grants from the Federal Vocational Rehabilitation Service, and much interest and stimulation from the National Institute of Mental Health.

Rehabilitation was defined as all efforts directed toward developing the optimal social adaptation of the individual. Although the ability to perform a task is one part, social adaptation frequently proved to be the larger and more difficult part of this process. The bettering of interpersonal relations, ability to function in a group and to meet frustrations in a competitive society were found to be of central importance.

This small book, packed full of good ideas and discussions, considered rehabilitation under four general headings: 1) general problems; 2) hospital aspects of rehabilitation; 3) transition from hospital to community; and 4) community aspects of rehabilitation.

Each section is thoughtfully presented and ably discussed. The summary, written by the editors, is excellent and most rewarding.

Joseph Joel Friedman, M.D.